Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-290
Employees' Manual, Title 8
Medicaid Appendix

November 21, 2008

ADVANCED REGISTERED NURSE PRACTITIONER MANUAL TRANSMITTAL NO. 08-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***ADVANCED REGISTERED NURSE PRACTITIONER MANUAL***, Title page, revised; Table of Contents, new; Chapter III, *Provider-Specific Policies*, Title page, new; Table of Contents (pages 1, 2, and3), new; pages 1 through 92, new; and the following forms:

470-2942	*Medicaid Prenatal Risk Assessment,* revised
470-0836	*Certification Regarding Abortion,* revised
470-0835	*Consent for Sterilization,* revised
470-0835S	*Consent for Sterilization,* revised
RC-0080	*Screening Components by Age*, new
470-0829	*Request for Prior Authorization*, new
470-3970	*Prior Authorization Attachment Control*, new
CMS-1500	*Health Insurance Claim* revised
470-3969	*Claim Attachment Control*, new
RA-1500	*Remittance Advice*, revised

Summary

Chapters on coverage and limitations and on billing and payment for advanced registered nurse practitioners are combined and revised to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters.

Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make the chapters quicker to load on line and easier to read and update.

This release:

- updates descriptions in the EPSDT Screening Components to reflect current standards
- Removes form 470-3163, *Child Mental Health Screen*. A variety of screening tools can be used in primary care settings to discover indications of mental health problems.
- Adds sections on prescription of drugs and medical supplies and adds information about enhanced services for pregnant women.
- Revises the prenatal risk assessment and abortion forms.
- Adds the prior authorization form and attachment form.
- Updates the claim form and claim attachment form.

Effective Date

November 1, 2008

Material Superseded

Remove the entire Chapter E and Chapter F from the ***ADVANCED REGISTERED NURSE PRACTITIONER MANUAL*** and destroy them. This includes the following:

Page	Date
Title Page	Undated
Contents (pp. 4, 5, 6)	December 1, 2003
Chapter E	
1-10	December 1, 2003
11, 12 (470-0836)	9/99
13-16	December 1, 2003
17, 18 (470-2942)	5/03
19-27	December 1, 2003
27, 28 (470-0835)	7/03
29, 30 (470-0835S)	7/30
30-37	December 1, 2003
38-40 (470-3165)	8/95
41-83	December 1, 2003
Chapter F	
1-8	December 1, 2003
9, 10 (HCFA-1500)	8/88
11 (470-3969)	7/03
12-18	December 1, 2003
19 (470-3744)	10/02
20 (470-0040)	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise

Iowa Department of Human Services

Advanced Registered Nurse Practitioner

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. COVERAGE AND LIMITATIONS

A. CONDITIONS OF PARTICIPATION

An advanced registered nurse practitioner (referred to as "ARNP") is defined by Iowa Board of Nursing rules at 655 Iowa Administrative Code Chapter 7 as being

> "…prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship.
>
> "Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists."

To be eligible to participate in the Medicaid program, an ARNP in Iowa must both:

- Be licensed by the state of Iowa as an ARNP, and
- Possess evidence of certification in a recognized specialty area, as defined in Board of Nursing.

The Medicaid program covers all types of ARNPs, in compliance with Iowa Code section 249A.4(7). These include:

- Certified clinical nurse specialist, an ARNP prepared at the master's level who possesses evidence of current advanced level certification as a clinical specialist in an area of nursing practice.
- Certified nurse-midwife, an ARNP educated in the disciplines of nursing and midwifery who is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.
- Certified nurse practitioner, an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care.
- Certified registered nurse anesthetist (CRNA), an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current advanced level certification or recertification.

Of the ARNP specialties able to enroll, only CRNAs have additional specific coverage provisions. For all other types of ARNPs able to enroll, the general provisions indicated in this manual apply.

In addition to being licensed by the state in which the CRNA practices, a CRNA must meet the following requirements:

- Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, or
- Has graduated in the past 18 months from a nurse anesthesia program that meets the Standards on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

ARNPs in other states are eligible to participate if they are licensed in that state and are certified by that state in a practice area recognized by the Iowa Board of Nursing.

B. COVERAGE OF SERVICES

Payment will be approved through the Medicaid program for services provided by ARNPs within their licensure and scope of practice, pursuant to Board of Nursing rules and definitions, including medically delegated functions under a collaborative practice agreement.

"Collaborative practice agreement" means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision-making and is based on the preparation and ability of each practitioner.

Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth in the following sections.

No payment will be made for services of a private-duty nurse.

1. Routine Physical Examination

A routine physical examination is one performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

Iowa Department of Human Services

MEDICAID PRENATAL RISK ASSESSMENT

Primary provider name	Provider phone number	Date
Client name	Phone number	Client date of birth
Address		Medicaid ID number

Gestational age at initial assessment: Weeks Date	Gestational age at rescreen: Weeks Date

Instructions: Write the score that applies to each risk factor. (* For risk factor definitions and nutrition screen, see back.)

Risk Factor/Value	A Score Initial
Maternal age 20-40 = 0 16-19 or >40 = 4 ≤ 15 = 10	
Education GED or 12 = 0 ≤ 11 = 2 ≤ 8 = 4	
Marital status married = 0 single, divorced, separated = 2	
Height >5 feet = 0 ≤ 5 feet = 3	
Prepregancy weight low (BMI < 19.8) = 2 obese (BMI > 29.0) = 2	
AB 1st trimester * < 3 = 0 ≥ 3 = 1	
AB 2nd trimester * none = 0 1 = 5 ≥ 2 = 10	
Race white = 0 black = 2 other = 1	
Cone biopsy/LEEP no = 0 yes = 3	
Uterine anomaly * no = 0 yes = 10	
Previous SGA baby no = 0 yes = 10	
Hx preterm labor * or preterm delivery no = 0 yes = number x 10	
Bleeding gums/never been to dentist no = 0 yes = 5	
Cigarette use/day 1 cig – 1/2 ppd = 1 > 1/2 ppd = 4	
Illicit drug use * (this pregnancy) no = 0 yes = 5	
Alcohol use * (this pregnancy) no = 0 yes = 2	
Initial prenatal visit * < 16 wks = 0 > 16 wks = 2	
Poor social situation * no = 0 yes = 5	
Children ≤ 5 years at home 0 or 1 = 0 ≥ 2 = 2	
Employment * none = 0 outside school/work = 1 heavy work = 3	
Last pregnancy within 1 year of present pregnancy no = 0 yes = 1	
Subtotal A	

Risk Factor Current Pregnancy/Value	B1 Initial OB	B2 Rescreen 28 wks+
Bacteriuria,* chlamydia, GC this pregnancy no = 0 yes = 3		
Pyelonephritis * no = 0 yes = 5		
Fibroids no = 0 yes = 3		
Presenting part engaged < 36 weeks no = 0 yes = 3		
Uterine bleeding ≥ 12 weeks * no = 0 yes = 4		
Cervical length < 1 cm < 34 weeks no = 0 yes = 4		
Dilation ≥ 1 cm * no = 0 yes = 4		
Uterine irritability * ≤ 34 weeks no = 0 yes = 4		
Placenta previa at < 30 weeks no = 0 yes = 4		
Oligohydramnios no = 0 yes = 10		
Polyhydramnios no = 0 yes = 10		
Multiple pregnancy no = 0 yes = 10+		
Surgery (abdominal * ≥ 18 weeks or cerclage) no = 0 yes = 10		
Depression ♦ Over the past 2 weeks have you ever felt down, depressed or hopeless? ♦ Over the past 2 weeks have you felt little interest or pleasure in doing things? (to either) no = 0 yes = 10		
Weight gain at 22 weeks ≥ 7 lb. = 0 < 7 lb. = 2		
Weight loss < 5 lb. = 0 ≥ 5 lb. = 3		
Urine protein 0/trace = 0 1+ = 2 > 1+ = 5		
Hypertension * or HTN medications no = 0 yes = 10		
Hemoglobin Hematocrit < 11 = 3 < 33 = 3		
Subtotal B1 and B2		

Other: _____ Additional risk factors indicating need for enhanced services. (See back for examples.) Points need not total 10.

Subtotal A		Subtotal A	
Subtotal B1	+	Subtotal B2	+
Total 1st OB		Total 28 weeks screen	

Total score of 10 points or more = high risk for preterm delivery. Check all enhanced antepartum management services that apply and indicate who will be the primary provider of each service.

- ❑ Care coordination _____
- ❑ Health education _____
- ❑ Psychosocial _____
- ❑ High risk follow-up _____
- ❑ Nutrition counseling _____
- ❑ Home visit _____
- ❑ Oral health _____
- ❑ Medical transportation _____

Signature of primary provider Date	Client signature: Release of information Date
Date of referral for WIC services:	(State WIC Office – 1-800-532-1579)

Risk Factor Definition

AB 1st trimester: More than three spontaneous or induced abortions at less than 13 weeks gestation. (Do not include ectopic pregnancies.)

AB 2nd trimester: Spontaneous or induced abortion between 12 and 19 weeks gestation.

Uterine anomaly: Bicornate, T-shaped, or septate uterus, etc.

Dental visit: Routine preventive dental care; not visit for emergency extraction, mouth trauma.

DES exposure: Exposure to diethylstilbesterol in utero. Patient who has anomalies associated with diethylstilbesterol receives points for this item and uterine anomaly.

Hx PTL: Spontaneous preterm labor during any previous pregnancies (whether or not resulting in preterm birth) or preterm delivery.

Hx pyelonephritis: One or more episodes of pyelonephritis in past medical history.

Illicit drug use: Any street drug use during this pregnancy, e.g., speed, marijuana, cocaine, heroin (includes methadone), huffing, or the recreational use of Rx or OTC drugs.

Alcohol use: Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking.

Initial prenatal visit: First prenatal visit at or after 16 weeks gestation.

Poor social situation: Personal or family history of abuse, incarceration, homelessness, unstable housing, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support system, low self esteem.

Employment:
Light work = part time or sedentary work or school
Heavy work = work involving strenuous physical effort, standing, or continuous nervous tension, such as, nurses, sales staff, cleaning staff, baby-sitters, laborers

Bacteriuria: Any symptomatic or asymptomatic urinary tract infection, i.e., 100,000 colonies in urinalysis.

Pyelonephritis: Diagnosed pyelonephritis in the current pregnancy. (Give points for pyelonephritis only, not both pyelonephritis and bacteriuria.)

Bleeding after 12th week: Vaginal bleeding or spotting after 12 weeks of gestation of any amount, duration, or frequency which is not obviously due to cervical contact.

Dilation (Internal os): Cervical dilation of the internal os of one cm or more at 34 weeks gestation.

Uterine irritability: Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks.

Surgery: Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy.

Hypertension: Two measurements showing an increase of systolic pressure of 30 mgHg above baseline, an increase in diastolic pressure of 15 mgHg above baseline, or both.

Nutritional Risk Factor Assessment and Definitions

Instructions: Check nutrition counseling if any of the factors below indicate nutritional risk.

Anemia:

Hgb < 11 or Hct < 33 (weeks 1-13 and weeks 27-40+)
Hgb < 10.5 or Hct < 32 (weeks 14-26)

Inappropriate nutrition practices:

- Consuming potentially harmful dietary supplements (includes excessive doses and those that may be toxic or harmful in other ways)
- Consumes diet very low in calories or essential nutrients (includes vegan diet defined as consuming only fruits, vegetables, and grains; macrobiotic diet; food faddism; and impaired calorie intake or nutrient absorption following bariatric surgery)
- Pica
- Inadequate iron supplementation (< 30 mg/day)
- Consuming foods potentially contaminated with pathogenic bacteria (raw seafood, meat, poultry, and eggs or any foods containing these products; raw sprouts; undercooked meat, poultry, and eggs; unpasteurized milk or foods containing it; soft cheeses such as feta, Brie, Camembert, blue-veined and Mexican-style cheese; unpasteurized fruit or vegetable juices; and hot dogs and luncheon meats unless reheated until steaming hot)

Examples of additional risk factors:

Medical	♦ Autoimmune disease ♦ Current eating disorder, fasting, skipping meals ♦ Diabetes ♦ Febrile illness ♦ Gestational diabetes ♦ Heart disease ♦ History of gastric bypass ♦ HIV ♦ Hyperemesis ♦ Psychiatric disorder ♦ Renal disease ♦ Seizure disorders ♦ Thyroid disease ♦ Type I diabetes
OB History	♦ Caesarean section ♦ Infertility ♦ Perinatal loss
Psychosocial	♦ Ambivalent, denying, or rejecting of this pregnancy ♦ Child care stress ♦ Cultural or communication barriers ♦ History of mental illness ♦ Not compliant with visit or healthy pregnancy behaviors (or not expected to be compliant without additional intervention) ♦ Teen pregnancy

- **For children**

  Federal Medicaid requirements place special emphasis on early and periodic screening and diagnosis for children to ascertain physical and mental defects and provide treatment for conditions discovered. See Care for Kids Screening Examinations for more information.

  When billing routine examinations for children:

  - Use diagnosis code V20.2 for members 0-18 and
  - Use diagnosis code V70.5 for members ages 19 or 20.

- **For adults**

  Adult members may receive an annual preventative physical examination. This examination should be unrelated to a specific disease, injury, illness, or complaint. Use diagnosis code **V70.0** or **V70.9** consistent with the coding conventions described in ICD-90CM. Additional diagnoses can be listed as secondary.

  To bill this service, bill the appropriate evaluation and management procedure code from CPT along with **V70.0** or **V70.9** primary diagnosis. All diagnosis pointers on the claim should point to the primary diagnosis.

  Laboratory services are covered as appropriate for an initial preventative examination and should also be billed using V70.0 or V70.9 as the primary diagnosis. Additional treatment resulting from the annual examination (if necessary) should be billed with diagnosis codes appropriate for those conditions.

2. Prenatal Risk Assessment

Medicaid-eligible pregnant women shall have a determination of risk using form 470-2942, *Medicaid Prenatal Risk Assessment*, upon entry into care. To view a sample of this form on line, click here.

A supply of assessment forms may be obtained from the IME Provider Services Unit on request. (See Chapter I, Form Orders.) The forms can also be printed or downloaded from the IME web site:
http://www.ime.state.ia.us/Providers/Forms.html

The Iowa Departments of Human Services and Public Health jointly developed form 470-2942. The form was designed to help clinicians determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

Keep a copy of form 470-2942 in the member's medical records.

When a **high-risk** pregnancy is reflected, inform the woman and provide a referral for enhanced services. Give a copy of form 470-2942 to the enhanced services agency.

When a **low-risk** pregnancy is reflected, complete a second determination:

- At approximately 28 weeks of care, or
- When you determine there is an increase in the pregnant woman's risk status.

a. How to Use the Risk Assessment Form

The left side of form 470-2942, *Medicaid Prenatal Risk Assessment*, includes medical, historical, environmental, and situational risk factors. A description of many of the risk factors is included on the back of the form. Included are AB first trimester, AB second trimester, uterine anomaly, HX pyelonephritis, illicit drug use, and poor social situation.

Give cigarette smoking a point value if the member smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."

Indicate the risk factor "Last birth within 1 year" when the member has been pregnant within one year of the beginning of the present pregnancy.

The right side of the form includes risk factors related to the current pregnancy. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the middle or last trimester. For this reason, these risk factors are assessed twice during the pregnancy.

Depression has an impact on the development and management of pregnancy related complications. Untreated depression has been associated with unfavorable health behaviors in pregnancy and subsequent fetal growth restrictions, preterm delivery, placental abruption, or newborn irritability.

Using the following two questions to screen for depression may be as effective as more lengthy tools.

- Over the past two weeks, have you ever felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

A positive response to both questions suggests the need for further evaluation. A positive response to one of these questions is sufficient to provide services for a high-risk pregnancy.

(Source: *Psychosocial Risk Factors: Prenatal Screening and Interventions*, ACOG Committee Opinion No 343, American College of Obstetricians and Gynecologists, Obstet Gynocal 2006, 108.469-77.)

Use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These are common examples only and are not meant to be a comprehensive list.

To determine the member's risk status during the current pregnancy, add the total score value on the left side and either the B1 column (score value at the initial visit) or the B2 column (score value at a visit between 24 and 28 weeks gestation) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

b. Referral for Enhanced Services

Maternal health centers work with physicians to provide "enhanced" services for higher-risk pregnant women. Enhanced services include:

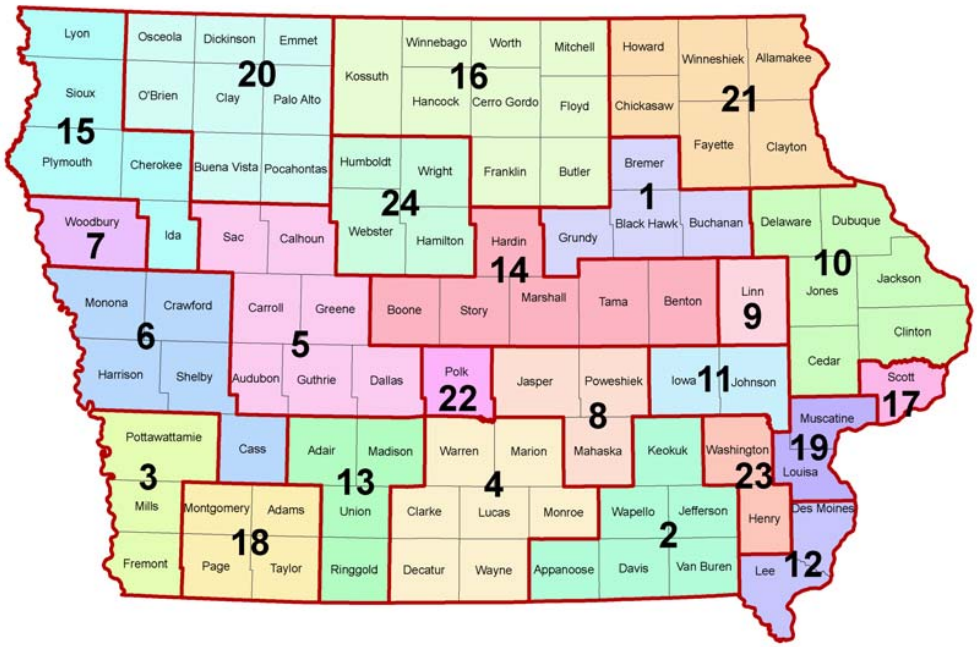
- Health education services
- Nutrition services
- Psychosocial services

These enhanced services are aimed at promoting better birth outcomes for Medicaid-eligible pregnant women in Iowa. The referral process allows these members to access additional services that Medicaid does not provide under other circumstances. The primary medical care provider continues to provide the medical care.

These services are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, Caring for the Future: The Content of Prenatal Care. National studies have shown that low-income women who receive these services along with medical prenatal care have improved birth outcomes.

See the *Maternal Health Center Manual* for more information about enhanced services. The following pages list the maternal health centers in Iowa, their locations, and their service areas.

LOCATION OF MATERNAL HEALTH CENTERS



Maternal Health Services Funded by the Iowa Department of Public Health

1. **Allen Memorial Hospital**
   Women's Health Center
   233 Void Drive
   Waterloo, IA 50703
   (319) 235-5090

2. **American Home Finding Association**
   Family Health Center
   201 S. Market Street
   Ottumwa, IA 52501
   (641) 682-8784 (800) 452-1098

3. **Child Health Specialty Clinics**
   Iowa City
   100 Hawkins Drive
   Iowa City, IA 52242
   (319) 384-7292

   Pottawattamie County
   3501 Harry Langdon Blvd
   Council Bluffs, IA 51503
   (712) 309-0041 (866) 652-0041

4. **Community Health Services of Marion County**
   104 South Sixth Street, P.O. Box 152
   Knoxville, IA 50138
   (641) 828-2238

5. **Community Opportunities, Inc. dba New Opportunities, Inc.**
   603 W. 8th Street
   Carroll, IA 51401
   (712) 792-9266 ext 412 (800) 642-6330

6. **Crawford County Home Health, Hospice &PH**
   105 N. Main, P.O. Box 275
   Denison, IA 51442
   (712) 263-3303

7. **Crittenton Center**
   2417 Pierce Street, P.O. Box 295
   Sioux City, IA 51102
   (712) 255-4321

8. **Grinnell Regional Medical Center**
210 - 4th Avenue
Grinnell, IA 50112
(641) 236-2566

9. **Hawkeye Area Community Action Program, Inc.**
1515 Hawkeye Drive
Hiawatha, IA 52233
(319) 393-7811 ext. 1084

10. **Hillcrest Family Services**
Hillcrest-Mercy Maternal Health Clinic
102 Professional Arts Bldg. Mercy Drive
Dubuque, IA 52001
(563) 589-8595

11. **Johnson County Department of Public Health**
1105 Gilbert Court
Iowa City, IA 52240
(319) 356-6040 ext. 146

12. **Lee County Health Department**
2218 Avenue H
Ft Madison, IA 52627
(319) 372-5225 (800) 458-6672

13. **MATURA Action Corporation**
203 W. Adams Street
Creston, IA 50801
(641) 782-8431

14. **Mid-Iowa Community Action, Inc.**
126 South Kellogg, Suite 1
Ames, IA 50010
(515) 232-9020 (800) 890-8230

15. **Mid-Sioux Opportunity, Inc.**
418 Marion Street
Remsen, IA 51050
(712) 786-3418 (800) 859-2025

16. **North Iowa Community Action Organization**
300 - 15th Street NE
Mason City, IA 50401
(641) 423-5044 (800) 657-5856

17. **Scott County Health Department**
500 West River Drive
Davenport, IA 52801
(563) 336-3131

18. **Taylor County Public Health**
MCH of Southwest Iowa
405 Jefferson
Bedford, IA 50833
(712) 523-3405 (800) 425-0051

19. **Unity Health System**
1609 Cedar Street
Muscatine, IA 52761
(563) 263-0122 (563) 263-0520

20. **Upper Des Moines Opportunity, Inc.**
101 Robbins Ave. P.O. Box 519
Graettinger, IA 51342
(712) 859-3885

21. **Visiting Nurse Association of Dubuque**
1454 Iowa Street, P.O. Box 359
Dubuque, IA 52004
(563) 556-6200

22. **Visiting Nurse Services**
1111 - 9th Street, Suite 320
Des Moines, IA 50314
(515) 558-9970

23. **Washington County Public Health & Home Care**
110 North Iowa Avenue, Suite 300,
Washington, IA 52353
(319) 653-7758

24. **Webster County Public Health**
330 –1st Avenue North, Suite L-2
Fort Dodge, IA 50501
(515) 574-3842

3. Prescription of Drugs

Payment will be made for drugs when prescribed by a legally qualified practitioner. Payment will be made for drugs dispensed by a practitioner only if there is no licensed retail pharmacy in the community where the practitioner's office is located.

Provide the NDC number when billing for injections. Claims will be denied when the NDC number information is not provided. Claims will be paid only for injections that are rebatable. See the IME web site for the list of drugs with rebates. http://www.ime.state.ia.us/Providers/index.html.

Please consult the *Prescribed Drugs Manual* for details of Medicaid coverage of drugs.

a. Legend Drugs and Devices

Payment will be made for drugs and devices (e.g., diaphragms) requiring a prescription **by law** with the following exceptions:

- Drugs marketed by manufacturers that **do not** have a signed Medicaid rebate agreement. See www.ime.state.ia.us/Providers/Druglist.html for additional information.
- Drugs prescribed for a use other than the drug's medically accepted use.
- Drugs used to cause anorexia or weight gain. (Exception: payment will be made for lipase inhibitor drugs for weight loss with prior authorization).
- Drugs used for cosmetic purposes or hair growth.
- Drugs used to promote smoking cessation. (Exception: payment will be made for generic bupropion sustained-release products that are FDA approved for smoking cessation, for nonprescription nicotine patch and gum with prior authorization, and for varenicline with a prior authorization).
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.
- Drugs classified as less than effective by the Centers for Medicare and Medicaid Services.

- Drugs that require a prior authorization as specified under Authorization.
- Drugs used for fertility purposes.
- Drugs used for the treatment of sexual or erectile dysfunction.

Payment will also be made for insulin on a legally qualified practitioner's prescription, although a prescription is not legally required.

b. Drugs Requiring Prior Authorization

Drug products designated on the Preferred Drug List as "P" (preferred) or "R" (recommended) do not require prior authorization unless the drug has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Iowa Medicaid Preferred Drug List.

A preferred drug with conditions has "preferred" agents but must meet certain medical criteria and guidelines that coincide with current prior authorization guidelines.

Drug products designated "N" (nonpreferred) on the Preferred Drug List require prior authorization, with the primary criteria being failure on the preferred agents rather than clinical guidelines.

See www.iowamedicaidpdl.com for the current designations.

Drug products within a therapeutic class that are not selected as preferred will be denied for payment unless the prescriber obtains prior authorization. Payment for drugs requiring a prior authorization will be made only when:

- The drugs are prescribed for treatment of one or more conditions set forth for each, and
- The Iowa Medicaid prior authorization criteria have been met, and
- Approval is obtained through the prior authorization process.

EXCEPTION: In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug and reimbursement will be made.

See REQUEST FOR PRIOR AUTHORIZATION for forms and instructions.

The specific criteria for approval of a prior authorization request are available in chart format on the web site www.iowamedicaidpdl.com. The prior authorization criteria are also defined in the *Prescribed Drugs Manual*. (See Section B.3, Drugs Requiring Prior Authorization.)

The IME Drug Prior Authorization Unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

c. Noncovered or Limited Services

For injections related to diagnosis or treatment of illness or injury, the following specific exclusions are applicable:

- **Injections not indicated for treatment of a particular condition.** Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

  The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.

- **Injections not for a particular illness.** Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness, or injury. NOTE: The physician must obtain prior approval before employing an amphetamine or legend vitamin by injection. (See REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS.)

- **Method of injection not indicated.** Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

- **Allergenic extract injection.** Claims from suppliers of allergenic extract materials provided the patient for self-administration will be allowed according to coverage limits in effect for this service.

- **Excessive injections.** Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

  When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for

injections given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.

If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for administering drugs, it will be disallowed along with the noncovered injections.

d. Nonprescription Drugs

Payment for nonprescription drugs will be made in the same manner as for prescription drugs, except that a maximum allowable cost (MAC) is established at the median of the average wholesale prices of the chemically equivalent products available. No exceptions for reimbursement for higher cost products will be approved.

For more information on covered nonprescription drugs and current maximum allowable costs, see the *Prescribed Drugs Manual*, section III. B. COVERAGE OF SERVICES, 5. Nonprescription Drugs.

4. Prescription of Medical Supplies and Equipment

a. Medical Supplies

Most medical and sickroom supplies are covered when ordered by a practitioner and supplied by a medical item supplier for a specific rather than an incidental use. Certain items require specific documentation from the practitioner to substantiate medical necessity before reimbursement can be made to the dealer for the items.

No payment will be made for medical supplies for a member receiving care in a Medicare-certified skilled nursing facility. For a member receiving care in a nursing facility or intermediate care facility for the mentally retarded, payment will be approved only for the following (when prescribed by the practitioner):

- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Disposable irrigation trays or sets (sterile).
- Disposable catheterization trays or sets (sterile).

- Catheters (indwelling Foley).
- Disposable saline enemas (sodium phosphate type, for example).
- Diabetic supplies (needles and syringes, disposable or reusable; test-tape, Clinitest tablets, and Clinistix).
- Nutritional supplements and supplies (when approved).

b. Orthopedic Shoes, Appliances, and Prosthetic Devices

Payment will be made to medical appliance and orthopedic shoe dealers for items on the written prescription of the practitioner. Several items of medical equipment require specific documentation from the practitioner to substantiate medical necessity before reimbursement can be made to the dealer for the items. (Diagnosis of flat feet is not acceptable.)

Payment will also be made to shoe repair shops performing modifications on orthopedic shoes when the practitioner prescribes such modifications in writing. The prescription must include:

- The patient's diagnosis and prognosis (for custom-made shoes only).
- The reason the item is required.
- An estimate (in months) of the duration of the need.
- A specific description of any special features to be included (e.g., padding, wedging, metatarsal bars, build-up soles or heels).

Payment will be made to the practitioner for the examination, including required tests, to establish the need for orthopedic shoes. Tennis shoes are covered only when required for participation in school sport activities.

Medical supplies payable to a practitioner are limited to those incident to a practitioner's service and for which the member cannot be expected to leave the practitioner's office and go to a supplier.

No payment will be approved for walkers, wheelchairs, special beds, or other sickroom equipment for members receiving care in a nursing facility.

c. Nutritional Supplements

For enteral products and supplies, the dispensing provider must submit claims to IME with form 470-0829, *Request for Prior Authorization*. Prior authorization is no longer required for parenteral therapy.

For nutritional supplements and supplies for administering the nutritional supplements, the practitioner must prescribe the item and document the medical necessity.

Prescription or nonprescription nutritional supplements shall be approved for payment for a member who needs the supplement due to a specifically diagnosed disease or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods and cannot be managed by avoidance of certain food products.

The information submitted must identify other methods attempted to support the member's nutritional needs. The documentation indicating the patient's condition must be sufficient to meet the above requirements.

When nutritional supplements are approved, reasonable supplies to administer nutritional supplements are also covered.

This policy applies to members in their own homes or in a nursing facility, since the items in this section are also considered prosthetic devices.

NOTE: Some members require supplementation of their daily protein and calorie intake. Nutritional supplements are often given as a medicine between meals to boost protein or calorie intake. Medicaid does not cover nutritional supplementation.

5. Family Planning Services

Covered family planning services include the following:

- Examination and tests that are necessary before prescribing family planning services. (Please indicate in the description area of the claim form service that is related to family planning.)
- Contraceptive services.
- Supplies for family planning, including such items as an IUD, a diaphragm, or a basal thermometer.

Direct family planning services receive additional federal funds. Therefore, it is important to indicate family planning services on the claim form by adding modifier "FP" after the procedure code.

6. Foot Care

Payment will be made for removal of warts.

Routine foot care is **not** covered, unless the member has a complicating systemic disease that makes rendering of this routine service by a nonprofessional hazardous. Routine foot care includes:

- The cutting or removal of corns or calluses,
- The trimming of nails,
- Other hygienic or preventative maintenance care in the realm of self care, such as cleaning and soaking the feet,
- The use of skin creams to maintain skin tone of both ambulatory and bedfast patients,
- Application of topical medicine, and
- Any services performed in the absence of localized injury, illness, or symptoms involving the foot.

Cutting or removal of corns, calluses, or nails is not considered routine care when this care does present a hazard to the member because:

- There is a systemic disease such as diabetes mellitus, or
- Other conditions have resulted in circulatory embarrassment or areas of desensitization in the legs or feet.

When such services have been rendered, Item 19 of the CMS 1500 claim form **must** identify and describe the complicating systemic disease that makes rendition of the routine service by a nonprofessional hazardous.

7. Services of Auxiliary Personnel

Payment will be approved to the employing practitioner for services rendered by auxiliary personnel when:

- The services are performed incident to the ARNP's professional services; and
- The auxiliary personnel are employed by the ARNP and are working under the ARNP's direct personal supervision,

Auxiliary personnel of an ARNP could be nurses, other (employed) ARNPs, social workers, or other similar practitioners. An auxiliary person is considered an employee of the ARNP if the following conditions are met:

- The ARNP is able to control when, where, and how the work is done. This control need not actually be exercised by the ARNP.
- The ARNP sets work standards.
- The ARNP establishes job descriptions.
- The ARNP withholds taxes from the wages of the auxiliary personnel.

In the office, "direct personal supervision" means the employing ARNP must:

- Be present in the same office suite, not necessarily the same room, and
- Be available to provide immediate assistance and direction.

Outside the office, such as in a member's home, a hospital, an emergency room, or a nursing facility, "direct personal supervision" means the ARNP must be present in the same room as the auxiliary person.

NOTE: All types of ARNPs recognized by the Iowa Board of Nursing and certified as such under the Iowa law are exempt from the requirement for direct personal supervision.

Any ARNP who is employed by another ARNP and is rendering services independent of the employing ARNP may render service in the office setting, a hospital, or a nursing facility without supervision by the employing ARNP.

However, to the extent the employing ARNP has a supervisory relationship over the employed ARNP, the employing ARNP must still be available by telephone to provide supervision and direction as needed.

"Services incident to the professional service of the ARNP" means the service provided by the auxiliary person must be related to the ARNP's professional service to the member. If the ARNP has not or will not perform a personal professional service to the member, the clinical records must document that the ARNP has assigned the member's treatment to the auxiliary person.

Licensed dietitians employed by or under contract with ARNPs may provide nutritional counseling services to members aged 20 or under. Payment will be made to the employing ARNP.

In all cases, claims for services rendered by the employed auxiliary personnel incident to the employing ARNP's professional service must be submitted in the name and under the provider number of the employing ARNP. Payment will be made to the employing ARNP.

8. Transportation to Receive Medical Care

To help ensure that members have access to medical care within the scope of the program, the Department reimburses members under certain conditions for transportation to receive necessary medical care. Except for "Care for Kids" services, payment is made only when:

- It is necessary for the member to travel outside the community to receive needed medical care; or
- The member lives in a rural area and must travel to the nearest community to receive care.

Payment in all situations is limited to the nearest source of adequate and appropriate care. The member is reimbursed only for the distance to the nearest provider (nurse practitioner, doctor, dentist, etc.) who can provide the necessary service.

This policy is due to limited funds in the Medicaid program and is not intended to limit the free choice the member has concerning the provider from whom the member wishes to receive service.

The same policy applies if you refer a Medicaid member to a specialist or a hospital in another community. The Department will reimburse the member only for the distance to the nearest available specialist or hospital, unless you indicate that, in view of the diagnosis and condition of the member, a more distant specialist or hospital is the only appropriate source of care.

When there is a nearer specialist of the same type or a nearer hospital, the Department may contact you to verify the necessity of referral to the more distant provider.

Under the EPSDT "Care for Kids" program, local transportation is available for screening, diagnosis, or treatment. If a member is in need of these services, contact the designated Department of Public Health agency for assistance. See the Appendix for list of designated agencies.

9. Ambulance Services

Payment will be approved through the Medicaid program for ambulance service, providing the use of any other method of transportation is medically contraindicated by the member's condition. The member must be transported to the *nearest* hospital with appropriate facilities, from one hospital to another, or to a skilled nursing facility or licensed nursing home.

If the member who has been transferred to hospital with appropriate facilities is subsequently taken to another hospital in the same locality, payment for the second trip will be approved only if there is a valid reason for transporting the member (as opposed to the member's personal preference). Example: The member requires inpatient hospital services that were not available at the first hospital.

a. Noncovered Services

Payment will not be approved for the following:

- Transportation of a member from home or a nursing home to a provider's office or clinic (free-standing or hospital-based), or back, unless the transportation is required for specialized treatment available at that location.
- Transportation of a member from home or a nursing home to the outpatient department of a hospital, unless the trip was an emergency or otherwise medially necessary.
- Transportation from one private home to another.

- Transportation of a member to University Hospitals in Iowa City, unless the University Hospitals is the *nearest* hospital with facilities necessary to the care of the member.
- Transportation to obtain the services of a specific provider.

b. Medical Necessity

The Iowa Medicaid Enterprise (IME) Medical Services Unit is responsible for determining that ambulance service was medically necessary and that the condition of the member precluded any other method of transportation.

The IME relies on information from an ARNP, physician, or hospital to determine if the member's condition requires ambulance transportation. Therefore, all claims related to treatment provided in connection with ambulance transportation should continue sufficient information about the member's diagnosis and medical condition to substantiate the need for ambulance services.

The IME can generally pay claims without confirmation from the provider or the medical facility when:

- The member is admitted as a hospital inpatient.
- There is an emergency, such as a result of an accident, injury, or acute illness.
- Information submitted with the claim clearly indicates that ambulance service was necessary, showing diagnosis and treatment of the condition that gave rise to the need for ambulance service.

The IME **cannot** presume medical necessity for ambulance service in the following cases:

- The member is ambulatory;
- The member is not admitted as a hospital inpatient (except in accident cases);
- The member is transported regularly to the hospital outpatient department for continuing treatment and is regularly returned home;
- The member is transported between the hospital outpatient department and a nursing home where the member is living.

In these and similar cases, the Medical Services Unit may find it necessary to request information from the ambulance company (which may in turn request it from the ARNP or the hospital) to determine medical necessity and whether payment of a claim should be approved.

Your assistance is requested in supplying this information, when requested, to determine if Medicaid can cover ambulance.

C. SURGICAL PROCEDURES

1. Anesthesia Services

Payment for the services of a qualified CRNA may be made:

- To the CRNA who furnishes anesthesia services or
- To a practitioner or group practice (anesthesiology) with which the CRNA has an employment or contractual relationship.

When a CRNA practices and bills independent of any affiliation with a physician or physician group, payment will be made for the full scope of Medicaid-reimbursable anesthesia services authorized for CRNAs by state law and regulations.

Note also specific conditions for CRNA services under sections CONDITIONS OF PARTICIPATION and BASIS OF PAYMENT.

2. Preprocedure Surgical Review

The following is a list of the surgical procedures that are subject to preprocedure review. Major categories are indicated. Surgical procedures falling under those categories for which approval must be obtained are listed with their CPT-4 and ICD-9-CM codes.

Requests for review of these elective procedures must be in writing and must be submitted to:

IME Medical Services Unit
P.O. Box 36478
Des Moines, Iowa 50319

Procedure	CPT-4	ICD-9-CM
Bone marrow transplant	38240	41.00
	38241	41.01
		41.02
		41.03
		41.09
Stem cell transplant		41.04
		41.05
		41.06
		41.07
		41.08
Heart transplant	33945	37.51
Heart/lung transplant	33935	33.6
Liver transplant auxiliary	47135	50.51
Other transplant of liver	47136	50.59
Lung transplant (not otherwise specified)	32851	33.50
Unilateral lung transplant	32852	33.51
Bilateral lung transplant	32853	33.52
	32854	
Pancreas transplant	48554	52.80
		52.82
		52.83
High gastric bypass	43847	44.31
(Printen and Mason)	43646	44.38
	43644	
	43645	
Gastric stapling (gastroplasty)	43326	44.69
	43842	
	43843	
	43848	
Lap bands	43770	44.95
Revision	43771	44.96
Removal	43772	44.97
Adjustments	43773	44.98
Small bowel bypass	43846	45.91

3.Abortion

Iowa law restricts Medicaid abortion payment to the following situations:

- The attending practitioner certifies in writing based on professional judgment that the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- The attending practitioner certifies in writing based on professional judgment that the pregnant woman's life would be endangered if the fetus were carried to term.
- An official of a law enforcement agency or public or private health agency (which may include a family practitioner), certifies in writing that:
  - The pregnancy is the result of rape that was reported to the agency within 45 days of the date of the incident, and
  - The report contains the name, address, and signature of the person making it.
- An official of a law enforcement agency or public or private health agency (which may include a family practitioner) certifies in writing that:
  - The pregnancy resulted from incest that was reported to the agency within 150 days of the incident, and
  - The report contains the name, address, and signature of the person making it.
- Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

Federal funding is available to terminate a pregnancy that was the result of rape or incest. Federal funding is also available if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family practitioner is required as noted above. It is the responsibility of the member, someone acting in her behalf, or the attending practitioner to obtain the necessary certification from the agency involved.

Form 470-0836, Certification Regarding Abortion, shall be used document compliance with these requirements. (See Certification Regarding Abortion, 470-0836, for further instructions.)

All abortion claims must be billed with the appropriate ICD-9 abortion diagnosis and CPT abortion procedure code on the CMS claim. Documentation in addition to form 470-0836 identifying the reason for the abortion must be attached to the claim. This includes:

- The operative report.
- The pathology report.
- Laboratory reports.
- The ultrasound report.
- Progress notes.
- Other documents that support the diagnosis.

a. Certification Regarding Abortion, 470-0836

A copy of form 470-0836, *Certification Regarding Abortion*, must be attached to any provider's claim for services related to an abortion. To view a sample of this form on line, click here.

A supply of certification forms may be obtained from the IME Provider Services Unit on request. (See Chapter I, Form Orders.) The form can also be printed or downloaded from the IME web site: http://www.ime.state.ia.us/Providers/Forms.html

Payment cannot be made to the attending practitioner, to other practitioners assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if the required certification is not submitted with the claim for payment.

It is the responsibility of the practitioner to make a copy of form 470-0836, *Certification Regarding Abortion*, available to the hospital, other practitioners, CRNAs, anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other practitioners on abortion claims.

Iowa Department of Human Services

CERTIFICATION REGARDING ABORTION

I. CERTIFICATION BY PHYSICIAN

CERTIFY TO ONE OF THE FOLLOWING:

I certify that on the basis of my professional judgment:

❑ Life of the Mother. _____ suffers from
(Name and address of the mother)
a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.

❑ Fetus Deformed. The fetus carried by _____
(Name and address of the mother)
is physically deformed, mentally deficient, or afflicted with a congenital illness based on: _____

_____

_____
(Medical indications)

_____ _____
Signature of attending provider Date

II. CERTIFICATION BY AGENCY

1. Rape

I, _____, of _____ received
(Name of Official) (Name of Agency)
a signed form from _____
(Name and address of person reporting)
stating that _____ was the victim of an incident of rape.
(Name and address of the mother)
The incident took place on _____ and the incident was reported on _____
(Date) (Date)
The report included the name, address and signature of the person making the report.

_____ _____
Signature of official of law enforcement, public or private health agency which may include a family physician Date

2. Incest

I, _____, of _____ received
(Name of Official) (Name of Agency)
a signed form from _____
(Name and address of person reporting)
stating that _____ was the victim of an incest incident.
(Name and address of the mother)
The incident took place on _____ and the incident was reported on _____
(Date) (Date)
The report included the name, address and signature of the person making the report.

_____ _____
Signature of official of law enforcement, public or private health agency which may include a family physician Date

CONDITIONS FOR MEDICAID PAYMENT FOR ABORTIONS

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

1. Where the attending physician certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is only available in these situations if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

2. Where the attending physician certifies in writing on the basis of his/her professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.

3. If the pregnancy is the result of rape, and that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.

4. If the pregnancy is the result of incest and that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency or physician must so certify in writing.

A copy of the form, *Certification Regarding Abortion* (470-0836), must be attached to any Medicaid claim associated with the abortion. **Payment will not be made to the attending physician or to other physicians assisting in the abortion or to the hospital if the required certification is not submitted by the provider with the claim for payment.** It is the responsibility of the attending physician to make a copy of the certification available to the hospital and other physicians billing for the services associated with the abortion.

In the case of pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as set forth above. The recipient, someone acting in her behalf, or the attending physician is responsible for obtaining the necessary certification from the agency involved. The form, *Certification Regarding Abortion* (470-0836), is to be used for this purpose. It is also the responsibility of the physician to make a copy of the certification available to the hospital and any other physician billing for the service. This will facilitate payment to the hospitals and other physicians on abortion claims.

b. Coverage of Mifepristone (Mifeprex or RU-486)

Mifepristone, when used in combination with misoprostol, is used to terminate a pregnancy. All of the previous federal and state criteria for coverage of abortions apply to the use of Mifepristone (Mifeprex or RU-486). This includes the coverage criteria, form 470-0836, and medical records. The following codes are available for billing abortions:

S0190 Mifepristone, oral, 200 MG

S0191 Misoprostol, oral, 200 MCG

S0199 Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs.

The Medicaid program considers S0199 a 'global' code. The fee is set to cover all of the services identified in the description. Only codes S0190 and S0191 are to be billed in addition to this code. Bill these procedure codes on the CMS with the required certification form and medical records.

c. Noncovered Services

The following abortion related services are not allowed when the abortion is not covered by federal or state criteria:

- Practitioner and surgical charges for performing the abortion. These charges include the usual, uncomplicated pre- and post-operative care and visits related to performing the abortion.
- Practitioner charges for administering the anesthesia necessary to induce or perform an abortion.
- Hospital or clinic charges associated with the abortion. This includes the facility fee for use of the operating room; supplies and drugs necessary to perform the abortion, and charges associated with routine, uncomplicated pre- and post-operative visits by the member.
- Drug charges for medication usually provided to or prescribed for the patient who undergoes an uncomplicated abortion. This includes routinely provided oral analgesics and antibiotics to prevent septic complications of abortion and Rho-GAM (an immune globulin administered to Rh negative women who have an abortion).

- Charges for other laboratory tests performed before performing the non-covered abortion to determine the anesthetic or surgical risk of the member (e.g., CBC, electrolytes, blood typing).
- Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- Uterine ultrasounds performed immediately following an abortion.

d. Covered Services Associated With Noncovered Abortions

The following services are covered even if performed in connection with an abortion that is not covered:

- Services that would have been performed on a pregnant woman regardless of whether she was seeking an abortion, including:
  - Pregnancy tests.
  - Tests to identify sexually transmitted diseases.
  - Laboratory tests routinely performed on a pregnant member, such as Pap smear and urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B, and blood typing.
- Charges for all services, tests and procedures performed post abortion for complications of a non-covered therapeutic abortion, including charges for:
  - Services following a septic abortion.
  - A hospital stay beyond the normal length of stay for abortions.

NOTE: Family planning or sterilization must not be billed on the same claim with an abortion service. Bill these services separately from the abortion claim.

4. Sterilization

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering a person incapable of reproducing that is **not**:

- A necessary part of the treatment of an existing illness, or
- Medically indicated as an accompaniment to an operation of the genitourinary tract.

For purpose of this definition, mental illness and mental retardation are not considered an "existing illness."

a. Conditions

Medicaid payment may be made for the sterilization of a member when all of the following conditions are met:

- The member to be sterilized must voluntarily request the service.
- A knowledgeable informant must give the member an explanation of the procedures to be performed, upon which the member can base the consent for sterilization.
- The member must be advised that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing future care or loss of other program benefits to which the member might otherwise be entitled.
- An "informed consent" is required. The member must:
  - Be 21 years of age or older when the consent form is signed, **and**
  - Be mentally competent and noninstitutionalized as defined below.

Medicaid payment shall **not** be made for sterilization of a person who:

- Is under age 21 at the time of consent, or
- Is legally mentally incompetent or institutionalized.

A "legally mentally incompetent person" is a person who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the court declares the person competent for purposes that include the ability to consent to sterilization.

An "institutionalized person" is a person who:

- Is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- Is confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

NOTE: Reversal of sterilization is **not** a covered Medicaid service.

b. Informed Consent

"Informed consent" means the voluntary knowing assent from the person to be sterilized; after the person has been given a complete explanation of what is involved and has signed a written document to that effect.

The "informed consent" shall be obtained on form 470-0835 or 470-0835S, *Consent for Sterilization*. If the member is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The member may be accompanied by a witness of the member's choice.

The informed consent shall not be obtained while the member is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the person's state of awareness. The elements of explanation that must be provided are:

- A thorough explanation of the procedures to be followed and the benefits to be expected.
- A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- Counseling concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure. (Reversal of sterilization **is not** a covered Medicaid service.)
- An offer to answer any inquires concerning the proposed procedures.

The member must be 21 years of age or older at the time of consent. The "informed consent" must be obtained at least 30 days but not more than 180 days before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs.

When emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent form was obtained for the exception to be approved.

When a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed for the exception to be approved.

Iowa Department of Human Services

CONSENT FOR STERILIZATION

NOTICE: *Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.*

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for the
doctor or clinic
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FIP or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about temporary methods of birth control that are available and could be provided to me that would allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____.

The discomforts, risks, and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ _____ _____.
month *day* *year*

I _____, hereby consent of my own free will to be sterilized by _____, by a method called
doctor
_____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or
- Employees of programs or projects funded by that Department ,

but only for the purpose of determining if federal laws were observed.

I have received a copy of this form.

Signature	Month Day Year

The following race and ethnicity information is requested, but is not required:
Race and ethnicity designation (*please check*):

- ❑ White (not of Hispanic origin)
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ Asian or Pacific Islander
- ❑ American Indian or Alaska Native

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the person to be sterilized:

I have translated the information and advice presented orally to the person to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter	Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
name of person
consent form, I explained to him/her the nature of the sterilization operation, _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent	Date
Facility	
Address	

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____
name of person to be sterilized *date of sterilization operation*
I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a
specify type of operation
final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

*(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the person's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)*

(1) At least 30 days have passed between the date of the person's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the person's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ❑ Premature delivery; person's expected date of delivery _____
- ❑ Emergency abdominal surgery: (describe circumstances): _____

Physician	Date

FORMULARIO DE CONSENTIMIENTO REQUERIDO

NOTA: Si en cualquier momento decide no hacerse esterilizar ello no resultara en que se le retiren o retengan cualquiera de los beneficios proporcionados por programas o proyectos que reciben fondos del gobierno federal.

CONSENTIMIENTO PARA LA ESTERILIZACIÓN

He pedido y recibido informacion sobre la esterilización de _____ (*doctor o clinica*). Cuando me informé al respecto, se me dijo que la decisión de hacerme esterilizar es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no hacerme esterilizar. Si decido no hacerme esterilizar, esta decisión no afectará mis derechos a cuidados o tratamiento futuros. No perderé ninguno de los beneficios de programas que reciben fondos federales, como por ejemplo FIP o Medicaid que esté recibiendo en la actualidad o que pueda recibir en el futuro.

Entiendo que la esterilización se considera permanente e irrevocable. He decidido que no quiero quedar embarazada, tener hijos o procrear hijos.

Se me ha informado acerca de los métodos anticonceptivos que están disponibles y que se me podrán proporcionar, los que sí me permitirán tener un hijo o procrear un hijo en el futuro. He rechazado estas alternativas y he elegido el ser esterilizado(a).

Entiendo que seré esterilizado(a) por medio de una operación conocida bajo el nombre de _____. Los inconvenientes, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no se hará hasta por lo menos 30 días después de haber firmado este consentimiento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no hacerme esterilizar no resultará en que se me retiren cualquiera de los beneficios o servicios médicos proporcionados por fondos federales.

Tengo por lo menos 21 anõs de edad y naci el _____ (*mes*) _____ (*día*), _____ (*año*).

Yo, _____, por la presente consiento por mi propia voluntad a que me esterilice _____ (*doctor*), por el método conocido como _____.

Mi consentimiento se vence a los 180 días de la fecha de mi firma.

También consiento a que este formulario y otros antecedentes médicos sean puestos a la disposición de:

- Representantes del Departamento de Salud, Educación y Bienestar (Department of Health, Education and Welfare) o
- Empleados de programas o proyectos que operan con fondos de ese departamento, pero solamente para determinar si se han cumplido las leyes federales.

He recibido una copia de este formulario.

firma	*mes día año*

Se le pide que proporcione la siguiente información, pero esto no es obligatorio:

Raza y Designación Etnica (haga una marca):

- ❑ Negro (no de orígen hispano)
- ❑ Hispano
- ❑ Asiático o de Islas del Pacifico
- ❑ Indio Norteamericano o Nativo de Alaska
- ❑ Blanco (no de orígen hispano)

DECLARACION DEL INTERPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada:

He traducido la información y consejos incluídos dados en forma oral por la persona que obtiene este consentimiento, a la persona a ser esterilizada. También le he leído el formulario de consentimiento en el idioma _____ y le he explicado su contenido. Según mi mejor entender esta persona ha comprendido esta explicación.

intérprete	*fecha*

DECLARACION DE LA PERSONA QUE OBTIENE ESTE CONSENTIMIENTO

Antes de que _____ (*nombre de la persona*) firmara este formulario de consentimiento, le he explicado la naturaleza de la operación para la esterilización llamada _____, y el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los inconvenientes, riesgos y beneficios que la acompañan.

Advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarios. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ninguno de los servicios de salud o cualquier otro beneficio proporcionado con fondos federales.

De acuerdo a mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece tener capacidad mental suficiente. Esta persona ha solicitado en forma voluntaria, con pleno conocimiento de lo que implica, que la esterilicen y parece comprender la naturaleza y consecuencias del procedimiento.

firma de la persona que obtiene el consentimiento	*fecha*
establecimiento	
dirección	

DECLARACION DEL MEDICO

Poco antes de efectuar la operación para la esterilización de _____ (*nombre de la persona a ser esterilizada*) el _____ (*fecha de la operación*) le expliqué la naturaleza de la operación llamada _____ (*tipo de operación*) así como el hecho de que es un procedimiento final e irrevocable, así como los inconvenientes, riesgos y beneficios derivados del mismo.

He advertido a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarios. Le he explicado que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su consentimiento puede ser retirado en cualquier momento y que por ello no perdera ninguno de los cuidados médicos o beneficios proporcionados por fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y tiene la suficiente capacidad mental. Ha pedido voluntariamente y con pleno conocimiento el ser esterilizado(a) y parece comprender la naturaleza y consecuencias del procedimiento.

(Instruccciones para el uso de párrafos finales alternos: Utilice el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, en que la esterilización se efectúa menos de 30 días despúes de la fecha de la firma del formulario de consentimiento. En dichos casos, deberá usarse el segundo párrafo de los que siguen. Tache el párrafo que no utilice.)

(1) Por lo menos treinta días han transcurrido entre la fecha en que la persona firmó el formulario de consentimiento y la fecha en que se efectuó la operación de esterilización.

(2) Esta esterilización fue efectuada menos de 30 días pero mas de 72 horas después de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y de la información requerida):

- ❑ Parto prematuro
  Fecha en que debiera haber ocurrido el parto: _____
- ❑ Cirugía abdominal de emergencia: (describa las circunstancias)

_____

médico	*fecha*

c. Consent for Sterilization, 470-0835 and 470-0835S

The practitioner's copy of the *Consent for Sterilization,* 470-0835 or 470-0835S, must be completely executed in all aspects according to the above directions and attached to the claim in order to receive payment. No substitute form is accepted.

To view a sample of the English consent form on line, click here. To view a sample of the Spanish consent form on line, click here.

A supply of consent forms may be obtained from the IME Provider Services Unit on request. (See Chapter I, Form Orders.) The forms can also be printed or downloaded from the IME web site: http://www.ime.state.ia.us/Providers/Forms.html

A claim for services for sterilization may be denied, due to either failure to have the consent form signed at least 30 days but not more than 180 days before service is provided or failure to use the official *Consent for Sterilization*, 470-0835 or 470-0835S.

If so, any claim submitted by the hospital, anesthesiologists, assistant surgeon, or associated providers for the same procedure will also be denied. The hospital and other providers associated with the sterilization services must obtain a photocopy of the complete consent form, and attach it to their claim when submitted to the IME for payment.

All names, signatures and dates on the *Consent for Sterilization,* 470-0835 or 470-0835S, must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:

- The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the member to be sterilized.
- The information requested pertaining to race and ethnicity may be supplied voluntarily on the part of the member, but is not required.

It is the responsibility of the person obtaining the consent form to verify that the member requesting the sterilization is at least 21 years of age on the date that the member signs the form. If there is any question pertaining to the true age of the member, the birth date must be verified.

Any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control that are available to the member may complete the "Statement of Person Obtaining Consent."

The "Physician's Statement" must be completed fully and signed by the practitioner **performing** the sterilization and dated when signed.

One of the paragraphs at the bottom of this statement must be crossed out. Be sure to cross out the paragraph that does not apply to the situation. If paragraph two is appropriate, indicate the expected date of delivery and circumstances involving emergency abdominal surgery.

Since the practitioner performing the sterilization will be the last person to sign the consent form, the practitioner should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization that will submit a claim, e.g., hospital, anesthetist, assistant surgeon, etc.

The only signatures that should be on the completed consent form are those of the member, the interpreter, if interpretation services were provided, the person obtaining the consent, and the practitioner performing the sterilization.

d. Hysterectomies

Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization, and only when one or more of the following conditions are met:

- The member or her representative has signed an acknowledgment that she has been informed orally and in writing that the hysterectomy will make the member permanently incapable of reproducing.

  The statement must be signed by the member or representative and must be submitted with the claim for Medicaid payment. The following language is satisfactory for such a statement:

> *"Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.*
>
> *(Date) (Signature of Member or Person Acting on Her Behalf)"*

This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement can be submitted to the IME with the related claims.

The acknowledgement that the member received the explanation before the surgery should **not** be on the *Consent for Sterilization*, 470-0835 or 470-0835S.

- The member was already sterile before the hysterectomy. The practitioner must certify in writing that the member was already sterile at the time of the hysterectomy and has stated the cause of the sterility. The following language is satisfactory for such a statement:

> *"Before the surgery, this patient was sterile and the cause of that sterility was _____.*
>
> *(Practitioner's Signature) (Date)"*

This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement is submitted to the IME with the related claims.

Any statement or documentation stating the cause of sterility must be **signed and dated** by a physician or an ARNP. This includes history and physical, operative reports, or claim forms.

- The hysterectomy was performed as the result of a life-threatening emergency in which the practitioner determined that prior acknowledgment was not possible, and the practitioner includes a description of the nature of the emergency.

  If the practitioner certifies that the hysterectomy was performed in a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis and will be permitted only in extreme emergencies.

  Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus is a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information.

Copies of the statement or documentation required to determine the medical necessity of the hysterectomy shall be made available for every other Medicaid provider involved that will submit a claim, e.g., hospital, anesthetist, assistant surgeon.

D. CARE FOR KIDS SCREENING EXAMINATION

A screening examination must include at least the following:

- Comprehensive health and developmental history, including an assessment of both physical and mental health development.
- A comprehensive unclothed physical examination. This includes:
  - Physical growth.
  - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- Appropriate immunizations according to age and health history as recommended by the Vaccines for Children Program.
- Health education, including anticipatory guidance.
- Hearing and vision screening.
- Appropriate laboratory tests. These shall include:
  - Hematocrit or hemoglobin.
  - Rapid urine screening.
  - Lead toxicity screening for all children ages 12 to 72 months.
  - Tuberculin test, when appropriate.
  - Hemoglobinopathy, when appropriate.
  - Serology, when appropriate.
- Oral health assessment with direct dental referral for children over age 12 months.

The recommended schedule for health, vision, and hearing screening is as follows:

Child's Age	Number of Screenings Recommended	Recommended Ages for Screening
0 to 12 months	7	2-3 days,* 1, 2, 4, 6, 9, and 12 months
13 to 24 months	3	15, 18, and 24 months
3 to 6 years	4	3, 4, 5, and 6 years
7 to 20 years	7	8, 10, 12, 14, 16, 18, and 20 years

* For newborns discharged in 24 hours or less after delivery.

Iowa Department of Human Services

Screening Components by Age

Age	Infancy							Early Childhood					Late Childhood					Adolescence			
	2-3 [1] days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
HISTORY																					
Initial/Internal	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAM	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
MEASUREMENTS																					
Height/Weight	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Head Circumference	★	★	★	★	★	★	★	★	★	★											
Blood Pressure											★	★	★	★	★	★	★	★	★	★	★
NUTRITION ASSESS/EDUCATION	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH [2]																					
Oral Health Assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dental Referral							★			★	Every six months										
SENSORY SCREENING																					
Vision	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O	O	S	O	O
Hearing	O	S	S	S	S	S	S	S	S	S	S	O	O	S	S	S	O	S	S	O	S
DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT [3]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
IMMUNIZATION [4]	★		★	★	★			★	★			✪		★	★	★	✪				
PROCEDURES																					
Hgb/Hct				✪															✪		
Urinalysis													★						✪		
Metabolic screening [5]	★																				

KEY: ★ To be performed ✪ Perform test once during indicated time period

S Subjective, by history **O** Objective, by a standard testing method

Continued on next page.

HEMOGLOBINOPATHY	Only once (newborn screen) and offered to adolescents at risk.
TUBERCULIN TEST	For high-risk groups, annual testing is recommended. These are household members of persons with tuberculosis or others at risk for close contact with the disease: recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.
LEAD	Starting at 12 months, assess risk for high dose exposure.
GYNECOLOGIC TESTING	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
STD	When appropriate. (People with a history and risk factors for sexually transmitted diseases should be tested for chlamydia and gonorrhea.)
ANTICIPATORY GUIDANCE	Performed every visit.

[1] For newborns discharged in 24 hours or less after delivery.

[2] The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.

[3] By history and appropriate physical examination, if suspicious, by specific objective developmental testing.

[4] An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.

[5] The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia.

These recommendations for preventive health care represent a guide for the care of well children who:

- Receive competent parenting,
- Have not manifested any important health problems, and
- Are growing and developing satisfactorily.

Other circumstances may indicate the need for additional visits or procedures. Interperiodic screening, diagnosis, and treatment allow the flexibility necessary to strengthen the preventative nature of the program. Interperiodic screens may be obtained for a child:

- As required by foster care or educational standards and
- When requested.

If children or youth come under care for the first time at any point on the schedule, or if any of the items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

To view RC-0080, *Screening Components by Age*, on line, click here.

Federal regulations require the Department to maintain a record of the findings of the screening examination and follow up with the child's family to help ensure that the child receives any further diagnostic studies or treatment services recommended.

If a child is referred for treatment as a result of the screening examination, place the modifier "U1" after the procedure code.

1. History and Guidance

a. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the member's medical history. It includes an assessment of both physical and mental health development. Take the member's medical history from the member, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the member's history.

Take or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- Identification of specific concerns.
- Family history of illnesses.
- The client's history of illnesses, diseases, allergies, and accidents.
- Information about the client's social or physical environment that may affect the client's overall health.
- Information on current medications or adverse reaction/responses due to medications.
- Immunization history.
- Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background.
- Identification of health resources currently used.

b. Developmental Screening

Screening is a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment." The primary purpose of **developmental screening** is to identify children who may need more comprehensive evaluation.

The use of validated screening tools improves detection of problems at the earliest possible age. Each developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). Any interventions or referrals based on abnormal findings should be documented as well.

Developmental screening for young children should include the following four areas:

- Speech and language,
- Fine and gross motor skills,
- Cognitive skills, and
- Social and emotional behavior.

In screening children from birth to six years of age, it is recommended that you select recognized instruments. The best instruments have good psychometric properties, including adequate sensitivity, specificity, validity, and reliability, and have been standardized on diverse populations.

Parents report instruments such as the *Parents' Evaluation of Developmental Status* (PEDS), *Ages and Stages Questionnaires*, and the *Child Developmental Review* have excellent psychometric properties and require a minimum of time

No list of specific instruments is required for identifying developmental problems of older children and adolescents. However, the following principles should be considered in developmental screening:

- Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional, or other familiar person.
- Incorporate and review this information in conjunction with other information gathered during the physical examination.
- Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of the child as a component of overall health and well-being, given the child's age and culture.
- Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.
- Screening should not result in a label or premature diagnosis being assigned to a child. Report only that a condition was referred or that diagnostic treatment services are needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.

When you or the parent has concerns or questions regarding the functioning of the child in relation to expected ranges of activities after screening, make referral for developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

Developmental surveillance is different than developmental testing. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care.

Developmental surveillance is an important technique, which includes questions about the development as a part of the general developmental survey or history. It is not a "test" as such, and is not billable as a developmental screen.

Health care providers often use age-appropriate developmental checklists to record milestones during preventative care visits as part of developmental surveillance. A surveillance tool for children from birth through age five, the *Iowa Child Health and Developmental Record* (CHDR), is available at http://www.iowaepsdt.org/.

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under treatment. Focus screening on such areas of special concern as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.

For further information on developmental screening, see:

- The Care for Kids Provider web site at: http://www.iowaepsdt.org/;
- The Developmental Behavioral Online site of the American Academy of Pediatrics at: http://www.dbpeds.org/;
- The Assuring Better Child Development and Health (ABCD) Electronic Resource Center of the National Academy for State Health Policy at: www.abcdresources.org;
- The Commonwealth Fund's Child Development and Preventive Care web site at: http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=9134; or
- The National Center of Home Initiatives for Children with Special Needs web site of the American Academy of Pediatrics at: http://www.medicalhomeinfo.org/screening/index.html

c. Mental Health Assessment

Mental health assessment should capture in important and relevant information about the child as a person. It may include a psychosocial history such as:

- The child's **life-style**, home situation, and "significant others."
- A **typical day**--how the child spends the time from getting up to going to bed.
- **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the child's outlook on the future.
- **Sleep:** amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- **Toileting:** methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.
- **Speech:** hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- **Habits:** bed-rocking, head-banging, tics, thumb-sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- **Discipline:** parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- **Schooling** experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- **Sexuality:** relations with members of opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.

- **Personality:** degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self image.

Source: Boyle Jr., W.E. and Hoekelman, R.A. The Pediatric History, In Hoekelman, R.A. ed. *Primary Pediatric Care*, Second Edition, 1992.

Clinical screening tools can increase the identification of psychosocial problems and mental disorders in primary care settings. Moreover, such tools can provide an important framework for discussing psychosocial issues with families. These screening tools can be grouped into three general categories:

- Broad psychosocial tools that assess overall functioning, family history, and environmental factors; deal with a wide range of psychosocial problems; and identify various issues for discussion with the child or adolescent and family.

  An example of this type of tool is the *Pediatric Intake Form*, which can be used to assess such issues as parental depression and substance use, gun availability, and domestic violence (Kemper and Kelleher, 1996a, 1996b).

- Tools that provide a general screen for psychosocial problems or risk in children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1988, 1999).

- Tools that screen for specific problems, symptoms, and disorders, such as the *Conners' Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).

Often a broader measure such as the *Pediatric Symptom Checklist* is used first, followed by a more specific tool focused on the predominant symptom for those that screen positive on the broader measure.

Some of the more specific tools may not be readily available to primary care health professionals or may require specialized training.

To view the *Pediatric Symptom Checklist*, see http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_symptom_chklst.pdf

Source: Jellinek M Patel BP, Froehle MC, eds. 2002. Bright Futures in Practice: Mental Health – Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health.

d. Health Education / Anticipatory Guidance

Health education that includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- Assist the parents and youth in understanding what to expect in terms of the child's development.
- Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *2000 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, second edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or http://www.ncemch.org

View these lists as guidelines only. You are not required to include topics that are inappropriate for the child or limit topics that are appropriate for the child.

Suggested Health Education Topics: Birth - 18 Months

Oral Health	
Appropriate use of bottle and breast feeding	Non-nutritive sucking (thumb, finger, and pacifier)
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Teething and tooth eruption
Infant oral care: cleaning teeth and gums	First dental visit by age one
Early childhood caries	Feeding and snacking habits: exposure to carbohydrates and sugars
Transmission of oral bacteria	Use of cup and sippy cup
Injury Prevention	
Infant/child CPR	Exposure to sun and heat
Child care options	Safety locks
Child safety seat restraint	Lock up chemicals
Child safety seats	Restricted play areas on the farm
Importance of protective helmets	Smoke detectors
Electric outlets	Stairway gates, walkers, cribs
Animals/pets	Syrup of ipecac, poison control
Hot water heater temperature	Emergency telephone numbers
Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder, plastic bags	Water precautions: buckets, tubs, small pools
Mental Health	
Adjustment to new baby	Sibling rivalry
Balancing home, work, and school	Support from spouse and friends
Caretakers' expectations of infant development	Recognizing unique temperament
Responding to infant distress	Creating stimulating learning environments
Baby self regulation	Fostering baby caregiver attachment
Child care	
Nutrition	
Bottle propping	Managing meal time behavior
Breast or formula feeding to 1 year	Self feeding
Burping	Snacks
Fluid needs	Weaning
Introduction of solid foods at 4-6 months	
Other Preventive Measures	
Back sleeping	Effects of passive smoking
Bowel patterns	Fever
Care of respiratory infections	Hiccoughs
Crying or colic	Importance of well-child visits

Suggested Health Education Topics: 2 - 5 Years

Oral Health

- Appropriate use of bottle and breast feeding
- Fluoride exposure: toothpaste, water, topical fluoride and supplements
- Oral care: parental tooth brushing and flossing when the teeth touch
- Gingivitis and tooth decay
- Non-nutritive sucking (thumb, finger and pacifier)
- Teething and tooth eruption
- Regular dental visits
- Feeding and snacking habits: exposure to carbohydrates and sugars
- Use of sippy cup
- Dental injury prevention
- Sealants on six-year molars

Injury Prevention

- CPR training
- Booster car seat
- Burns and fire
- Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins
- Dangers of accessible chemicals
- Importance of protective helmets
- Machinery safety
- No extra riders on tractor
- Play equipment
- Purchase of bicycles
- Put up warning signs
- Restricted play areas
- Street danger
- Teach child how to get help
- Toys
- Tricycles
- Walking to school
- Water safety
- Gun storage

Mental Health

- Adjustment to increasing activity of child
- Balancing home, work, and school
- Helping children feel competent
- Child care
- Sibling rivalry
- Managing emotions

Nutrition

- Appropriate growth pattern
- Appropriate intake for age
- Control issues over food
- Managing meal-time behavior
- Physical activity
- Snacks

Other Preventive Measures

- Adequate sleep
- Care of illness
- Clothing
- Common habits
- Importance of preventative health visits
- Safety rules regarding strangers
- Social skills
- TV watching
- Age-appropriate sexuality education
- School readiness
- Toilet training
- Smoke-free environments

Suggested Health Education Topics: 6 - 12 Years

Oral Health	
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: supervised tooth brushing and flossing	Dental referral: orthodontist
Gingivitis and tooth decay	Diet and snacking habits: exposure to carbohydrates, sugars, and pop
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
Permanent tooth eruption	Sealants on 6- and 12-year molars
	Mouth guards for sports
	Smoking and smokeless tobacco
Injury Prevention	
Bicycle (helmet) safety	Emergency telephone numbers
Car safety	Machinery safety
CPR training	Mowing safety
Dangers of ponds and creeks	Self-protection tips
Electric fences	Sports safety
Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock	Street safety
	Tractor safety training
	Water safety
Fire safety	High noise levels
Gun and hunter safety	
Mental Health	
Discipline	Developing self esteem
Emotional, physical, and sexual development	Nurturing friendships
	Peer pressure and adjustment
Handling conflict	School-related concerns
Positive family problem solving	Sibling rivalry
Nutrition	
Appropriate intake for age	Inappropriate dietary behavior
Breakfast	Managing meal time behavior
Child involvement with food decisions	Peer influence
	Physical activity
Food groups	Snacks
Other Preventive Measures	
Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
	Stress
Smoke-free environments	TV viewing

Suggested Health Education Topics: Adolescent (13 - 21 Years)

Oral Health

- Fluoride exposure: toothpaste, water and topical fluoride
- Oral care: tooth brushing and flossing
- Gingivitis, periodontal disease and tooth decay
- Permanent tooth eruption
- Regular dental visits
- Dental referral: orthodontist and oral surgeon for third molars
- Diet and snacking habits: exposure to carbohydrates, sugars and pop
- Dental injury prevention
- Sealants on 6- and 12-year molars
- Mouth guards for sports
- Smoking and smokeless tobacco
- Drug use (methamphetamines)
- Oral piercing

Development

Normal biopsychosocial changes of adolescence

Gender Specific Health

- Abstinence education
- Contraception, condom use
- HIV counseling or referral
- Self breast exam
- Self testicular exam
- Sexual abuse, date rape
- Gender-specific sexual development
- Sexual orientation
- Sexual responsibility, decision making
- Sexually transmitted diseases
- Unintended pregnancy

Health Consumer Issues

- Selection and purchase of health devices or items
- Selection and use of health services

Injury Prevention

- ATV safety
- CPR and first aid training
- Dangers of farm ponds and creeks
- Falls
- Firearm safety, hunting practices
- Gun and hunter safety
- Handling agricultural chemicals
- Hearing conservation
- Machinery safety
- Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)
- Overexposure to sun
- ROPS (roll over protective structure)
- Seat belt usage
- Helmet usage
- Smoke detector
- Sports recreation, workshop laboratory, job, or home injury prevention
- Tanning practices
- Violent behavior
- Water safety
- High noise levels

Nutrition	
Body image, weight issues	Food fads, snacks, fast foods
Caloric requirements by age and gender	Selection of fitness program by need, age, and gender
Balanced diet to meet needs of growth	Special diets
Exercise, sports, and fitness	
Personal Behavior and Relationships	
Communication skills	Community involvement
Dating relationships	Relationships with adults and peers
Decision making	Self esteem building
Seeking help if feeling angry, depressed, hopeless	Stress management and reduction
	Personal responsibility
Substance Use	
Alcohol and drug cessation	Riding with intoxicated driver
Counseling or referral for chemical abuse	Sharing of drug paraphernalia
	Steroid or steroid-like use
Driving under the influence	Tobacco cessation
HIV counseling and referral	
Other Preventive Measures	
Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
	Stress
Smoke-free environments	TV viewing

2. Physical Examination

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- General appearance.
- Assessment of all body systems.
- Height and weight.
- Head circumference through 2 years of age.
- Blood pressure starting at 3 years of age.
- Palpation of femoral and brachial (or radial) pulses.

- Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education.
- Pelvic examination, recommended for women 18 years old and older, if sexually active, or significant menstrual problems.
- Testicular examination, include age-appropriate self-examination instructions and health education.

a. Growth Measurements

- **Recumbent Length:** Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8th inch.
- **Height:** Measure children over 2 years of age using a standing height board or stadiometer.

  If the child is two years old or older and less than 31 1/2 inches tall, the height measurement does not fit on the 2-20 year old chart. Therefore, you must measure the child's recumbent length and plot the length on the Birth-36 month growth chart. Read and record the measurement to the nearest 1/8th inch.

  Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.
- **Weight:** Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

  Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.
- **Body Mass Index:** Body Mass Index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals.

   Examples: 37 pounds 4 ounces = 37.25 pounds
   41 ½ inches = 41.5 inches

2. Insert the values into the formula:

   [weight (1b) / height (in) / height (in)] X 703 = BMI

   Example: (37.25 lb / 41.5 in / 41.5 in) X 703 = 15.2

A reference table can also be used to calculate BMI. This table can be downloaded from the Centers for Disease Control and Prevention web site at www.cdc.gov/growthcharts.

For children, BMI values are plotted against age. If the BMI-for-age is less than or equal to the 5th percentile, the child is considered underweight. If the BMI-for-age is between the 85th and 94th percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

- **Plotting Measurements:** Record measurements as soon as they are taken to reduce errors.

  Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for the children under 2 years of age. For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

  Example:

	Year		Month		Day		
Date of visit	~~93~~	92	~~7~~	~~6~~ 18	~~15~~	45	July 15, 1993
Birth date	-91		-10		-28		October 28, 1991
Age	1		8		17		= 20 months, 17 days or 21 months

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.

Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.

Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract birth date from the clinic visit date. You may borrow 30 days from the months column or 12 months for the year column when subtracting.

Common errors result from unbalanced scales, failure to remove shoes and heavy clothing, use of an inappropriate chart for recording the results, and uncooperative children.

- **Referral and Follow-up of Growth in Infants and Children**
  - Nutrition. See criteria in Nutritional Status.
  - Medical. Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:
    - Growth of less than 2 inches/year for ages 3 to 10 years.
    - A 25 percentile greater change in weight/height percentile rank.
    - Sudden weight gain or loss.
    - More than 2 SD below or above the mean for height.

b. Head Circumference

Measure the head circumference at each visit until the child is two years old. Measure with a nonstretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease & Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- Above the 95th percentile.
- Below 5th percentile.
- Reflecting a major change in percentile levels from one measurement to the next or over time.

c. Blood Pressure

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, do a blood pressure only if other physical findings suggest it may be needed.

The National Health, Lung and Blood Institute publishes blood pressure standards for children and adolescents from 1 through 17 years old based on height, as well as age and gender.

(1) Use of Blood Pressure Tables in a Clinical Setting

To use the tables, you need to measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age, and sex.

The National Heart, Lung and Blood Institute recommends using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

(2) Interpretation of Blood Pressure Readings

The interpretation of children and adolescents blood pressure measurements for height, age, and gender are as follows:

- Readings below the 90th percentile are considered normotensive.
- Reading between the 90th and 95th percentile are high normal and warrant further observation and identification of risk factors.
- Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.

Table 1. Blood Pressure Levels for Boys Aged 1 to 17 Years by Percentile of Height

Boys		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	94	95	97	98	100`	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	104	106	106	55	55	56	57	58	59	59
2 yr	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3 yr	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4 yr	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5 yr	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6 yr	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7 yr	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8 yr	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9 yr	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10 yr	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11 yr	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12 yr	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13 yr	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14 yr	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15 yr	90h	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16 yr	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17 yr	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89

* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

Table II. Blood Pressure Levels for Girls Aged 1 to 17 Years by Percentile of Height

GIRLS		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	105	107	107	57	57	57	58	59	60	60
2 yr	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3 yr	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4 yr	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5 yr	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6 yr	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7 yr	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8 yr	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9 yr	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10 yr	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11 yr	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12 yr	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13 yr	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14 yr	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15 yr	90h	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16 yr	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17 yr	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

d. Oral Health Screening

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive dental education is provided to the parents or guardians.

Unlike other health needs, dental problems are so prevalent that most children over 12 months will need diagnostic evaluation and treatment. The oral health screening should include all of the following and should be documented in the child's record:

- Complete or update the dental history:
  - Current or recent dental problems, including pain or mouth injuries;
  - Name of dentist; and
  - Date of child's last dental visit or length of time since last dental visit.
- Medical and dental history:
  - Current or recent medical conditions
  - Current medications used
  - Allergies
  - Name of child's dentist
  - Date of last dental visit or frequency of dental visits
  - Use of fluoride by child (source of water, use of fluoridated toothpaste or other fluoride products)
  - Current or recent dental problems or injuries
  - Home care (frequency of brushing, flossing, or other oral hygiene practices)
  - Snacking and feeding habits
- Oral evaluation
  - Number of teeth (for children up to age 12)
  - Presence of decay
  - Presence of demineralized areas (white spots)
  - Presence of visible plaque
  - Presence of gingivitis or other soft tissue conditions

- Presence of enamel defects
- Presence of sealants
- Presence of restored teeth

♦ Provide age-appropriate oral health education to parent or guardian. Education should be based on the findings of the oral health screening.

♦ Refer children to a dentist for:

- Complete dental examination annually starting at 12 months and semiannually starting at 24 months, unless a dentist recommends more frequent visits;
- Obvious or suspected dental caries;
- Pain or injury to the oral tissue; and
- Difficulty chewing

3. Laboratory Tests

a. Hemoglobin and Hematocrit

One hematocrit or hemoglobin determination is suggested by the American Academy of Pediatrics during the first year, and in each of the following intervals:

♦ 9-12 months, if any of the following risk factors are present:

- Qualify for EPSDT Care for Kids
- Low socioeconomic status
- Birth weight under 1500 grams
- Whole milk given before 6 months of age (not recommended)
- Low-iron formula given (not recommended)

♦ 11-20 years. Annual screening for females, if any of the following factors are present:

- Qualify for EPSDT Care for Kids
- Moderate to heavy menses
- Chronic weight loss
- Nutrition deficit
- Athletic activity

A test for anemia may be performed at any age if there is:

- Medical indication noted in the physical examination
- Nutritional history of inadequate iron in the diet
- History of blood loss
- Family history of anemia

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185% of poverty and hemoglobins or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Fifth Percent Criteria for Children

Age/Years	Hematocrit	Hemoglobin
6 months up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.5
8 up to 12 years	35.4	11.9
Female (non pregnant)		
12 up to 15 years	35.5	11.8
15 up to 18 years	35.9	12.0
18 up to 21 years	35.7	12.0
Male		
12 up to 15 years	37.3	12.5
15 up to 18 years	39.7	13.3
18 up to 21 years	39.9	13.5

Source: "Recommendations to Prevent and Control Iron Deficiency in the United States," *Morbidity and Mortality Weekly Report*, April 3, 1998; Vol. 47, No. RR-3, pages 1-29.

b. Urinalysis

Depending on the success in obtaining a voided urine specimen, urinalysis is suggested:

- At 5 years
- Once from 11 through 20 years, preferable at 14 years

Use a dipstick that shows at least pH, glucose, protein, blood, and nitrates. Referral criteria should include:

- PH below 5 or above 9
- Glycosuria
- 2+ protein
- Positive nitrates
- Trace or greater blood

c. Metabolic Screening

Confirm during the infant's first visit that newborn screening was done. In Iowa, newborn screening is mandatory for the following conditions:

- Congenital adrenal hyperplasia
- Galactosemia
- Hemoglobinopathies
- Hypothyroidism
- Phenylketonuria (PKU)
- Medium chain acyl Co-A dehydrogenase (MCAD) deficiency
- Biotinidase deficiency
- Hearing
- Cystic fibrosis
- Any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry

A current list of the screening panel can be found at:
http://www.idph.state.ia.us/genetics

d. Hemoglobinopathy Screening

Screen infants not born in Iowa and children of Caribbean, Latin American, Asian, Mediterranean, and African descent who were born before February 1988 for hemoglobin disorders. Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call 319-356-1400 for information.

e. Tuberculin Testing

The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin testing in **high-risk** children.

High risk children include those in households where tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and homes of IV drug users, alcoholics, HIV positives, and prostitutes).

f. Lead Testing

Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

For more information on assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, 555-281-3479 or 1-800-972-2026.

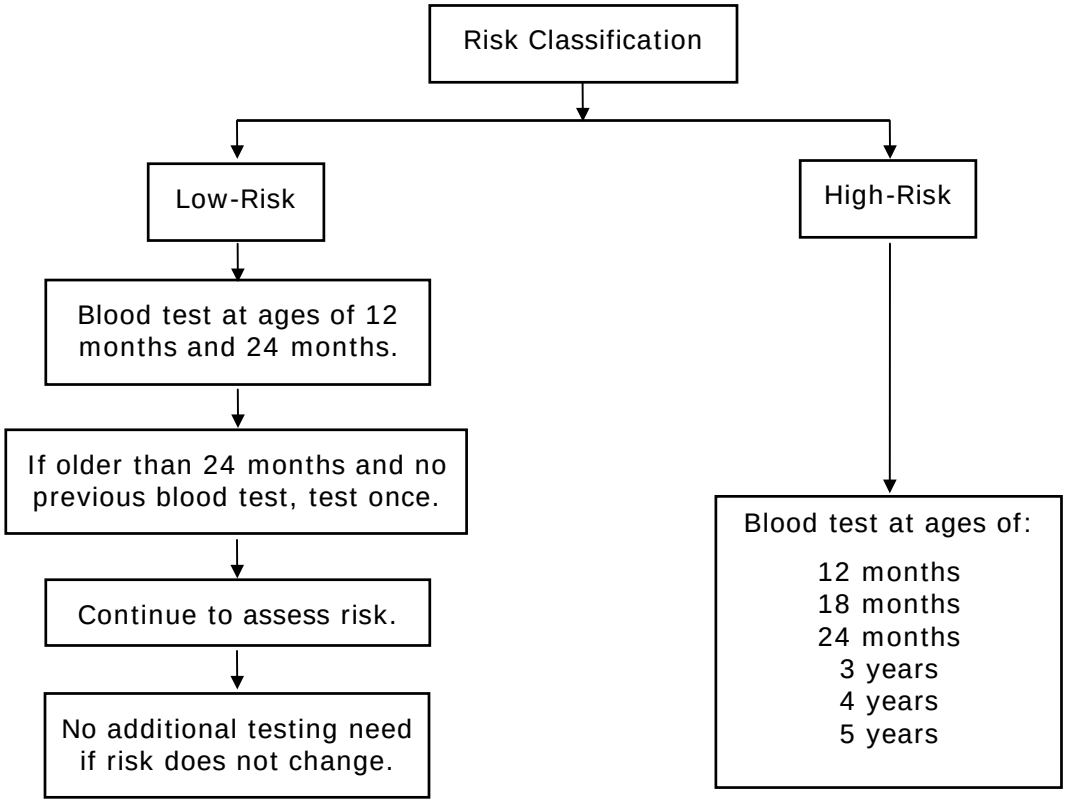
(1) Determining Risk Through Asking Questions

Beginning with the age of 12 months, ask the following questions for all children at each office visit to determine each child's risk for lead poisoning:

- Has your child ever lived in or regularly visited a house built before 1960 (including home, child care center, baby-sitter, relatives' home)?
- Have you noticed any peeling or chipping paint in or around the pre-1960 house that your child lives in or regularly visits?
- Is the pre-1960 home that your child lives in or regularly visits being remodeled or renovated by:
- Stripping, sanding, or scraping indoor our outdoor paint?
- Removing walls or tearing out lath and plaster?
- Does your child eat non-food items, such as dirt?
- Have any of your other children or their playmates had elevated lead levels ≥ 15 µg/dL?
- Does your child live with or frequently encounter an adult who works with lead on the job or in a hobby? (Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramic worker, stained glass worker, sheet metal worker, plumber.)
- Does your child live near a battery plant, battery recycling plant, or lead smelter?
- Do you give your child any home or folk remedies? (Examples: Azarcon, Greta, Pay-loo-ah)
- Does your child eat candy that comes from Mexico or is purchased from a Mexican grocery store?
- Has you child ever lived in Mexico, Central America, or South America or visited one of these areas for a period longer than two months?

If the answer to **any** of these questions is yes, the child is considered to be at high risk for lead poisoning and needs to be screened according to the high-risk screening schedule.

(2) Basic Lead Testing Chart (Based on Risk and Age)



NOTE: If you see children at different ages than these, you can change these schedules to correspond with the ages when you do see children. However, the first test should not be done before 12 months unless the child is at extremely high risk for lead poisoning.

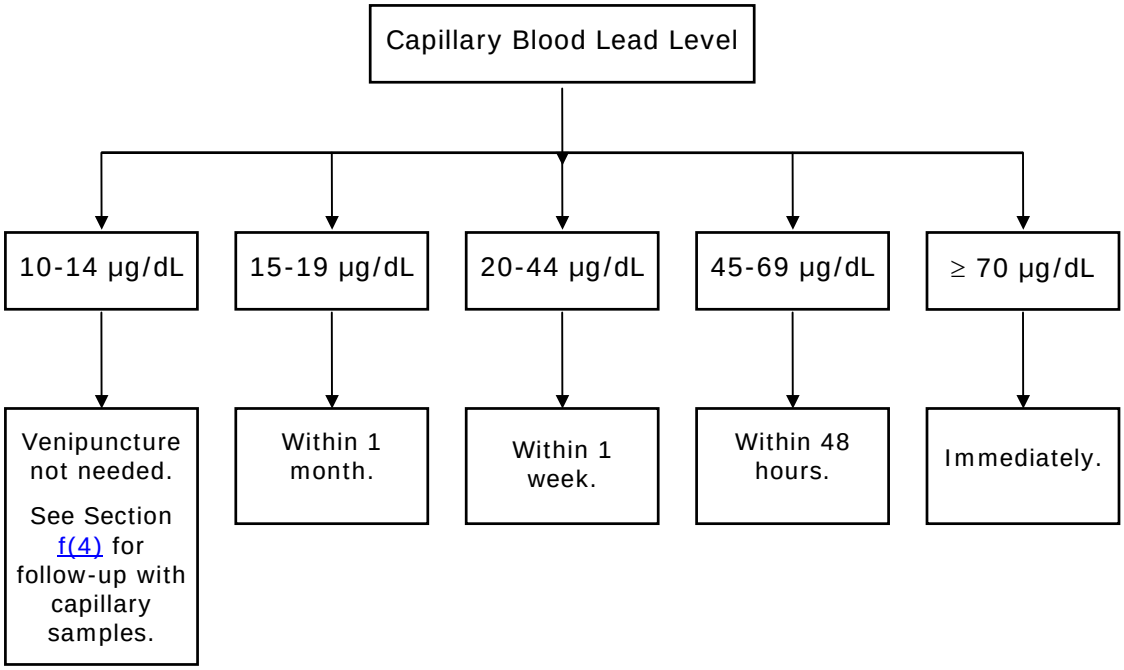
If capillary samples are used, see next page for follow-up of any level ≥ 10 µg/dL.

If venous samples are used, see Follow-up of Elevated Blood Lead Levels (10-14 µg/dL), Follow-up of Elevated Venous Blood Leads (15-19 µg/dL), and Follow-up of Elevated Venous Levels (≥ 20 µg/dL) for follow-up of any level ≥ 10 µg/dL.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(3) Schedule for Obtaining Confirmatory Venipunctures

Children who have blood lead levels ≥ 15 µg/dL on a capillary sample should have these levels confirmed on venous samples according to the timetables below.



If venous level < 9 µg/dL, return to regular blood lead testing schedule.

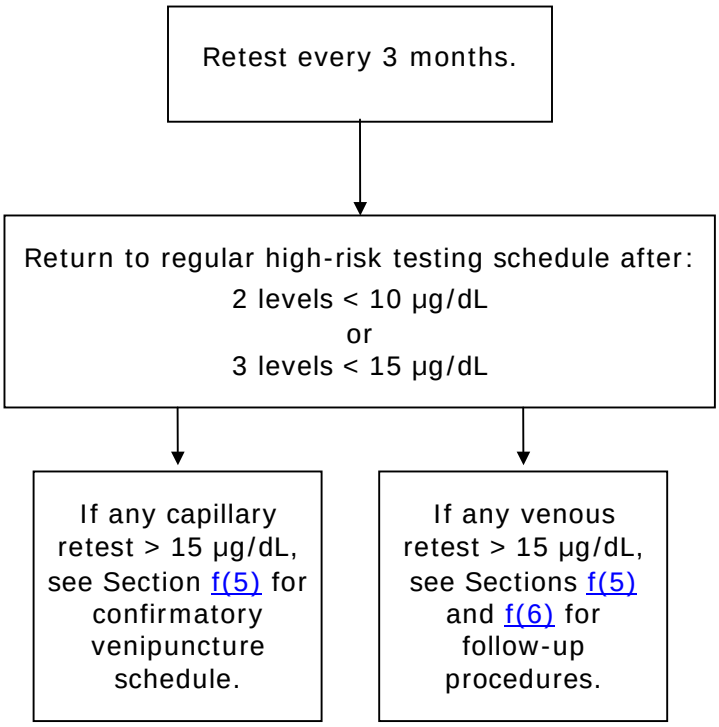
If venous level 10-14 µg/dL, see Follow-up of Elevated Blood Lead Levels (10-14 µg/dL).

If venous level 15-19 µg/dL, see Follow-up of Elevated Venous Blood Leads (15-19 µg/dL).

If venous level ≥ 20 µg/dL, see Follow-up of Elevated Venous Levels (≥ 20 µg/dL).

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

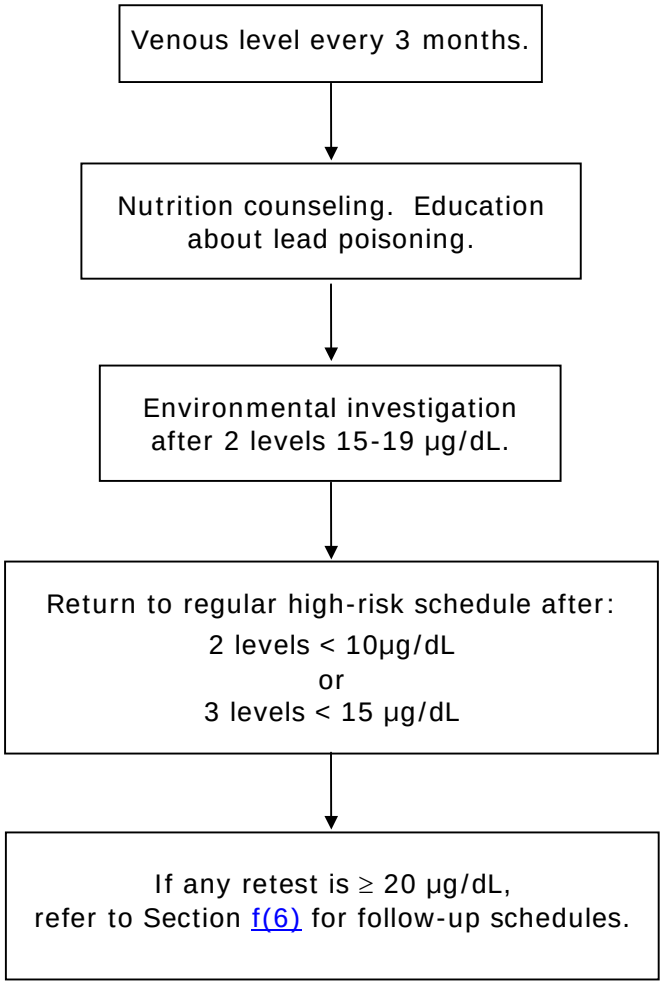
(4) Follow-up of Elevated Blood Lead Levels (10-14 µg/dL)



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(5) Follow-up of Elevated Venous Blood Leads (15-19 µg/dL)

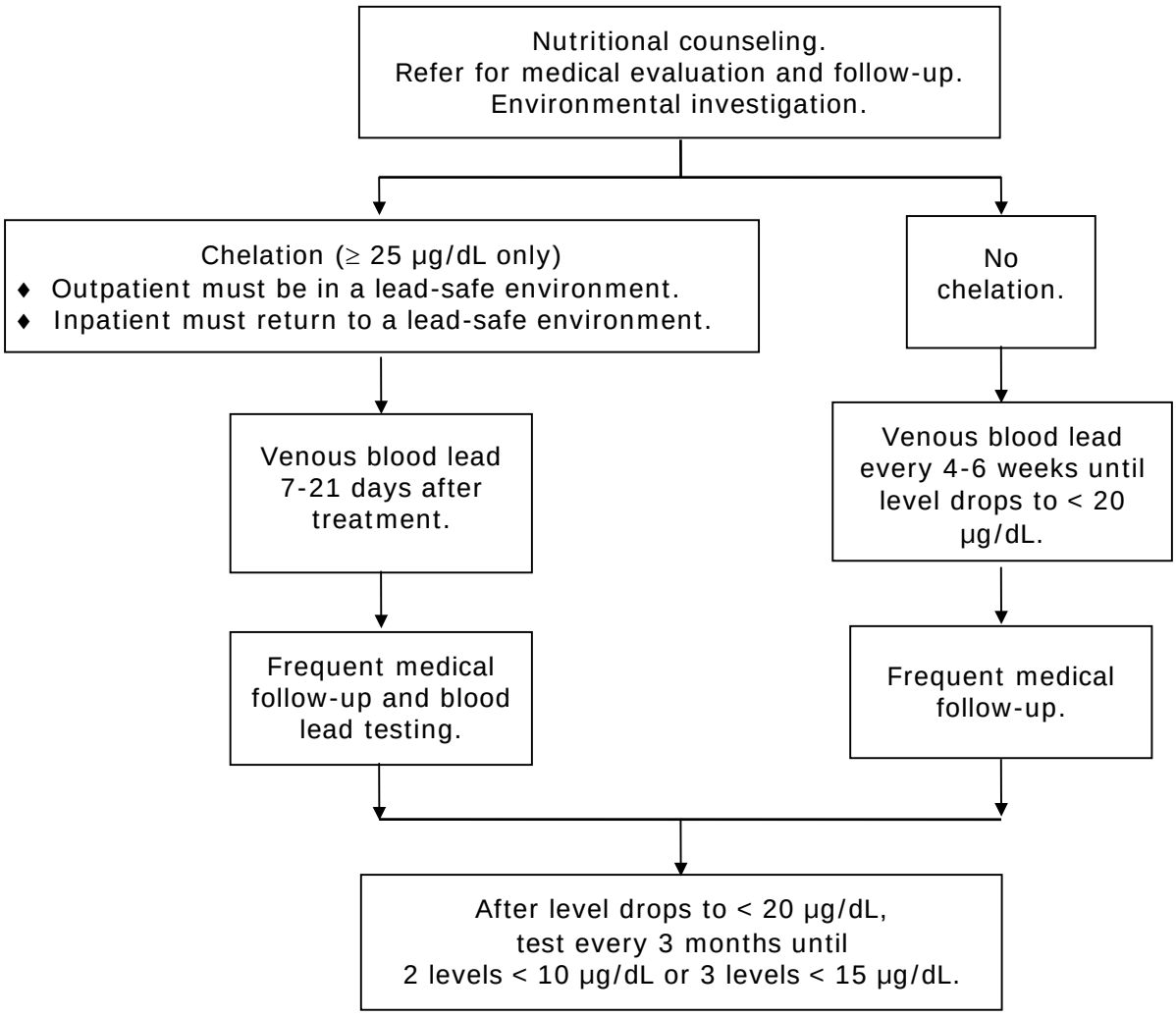
All children who have had venous levels ≥ 15 µg/dL are considered "high" risk regardless of initial risk assessment.



See Timelines for Medical and Nutritional Follow-up and Timelines for Environmental Follow-up for time frames for referrals.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

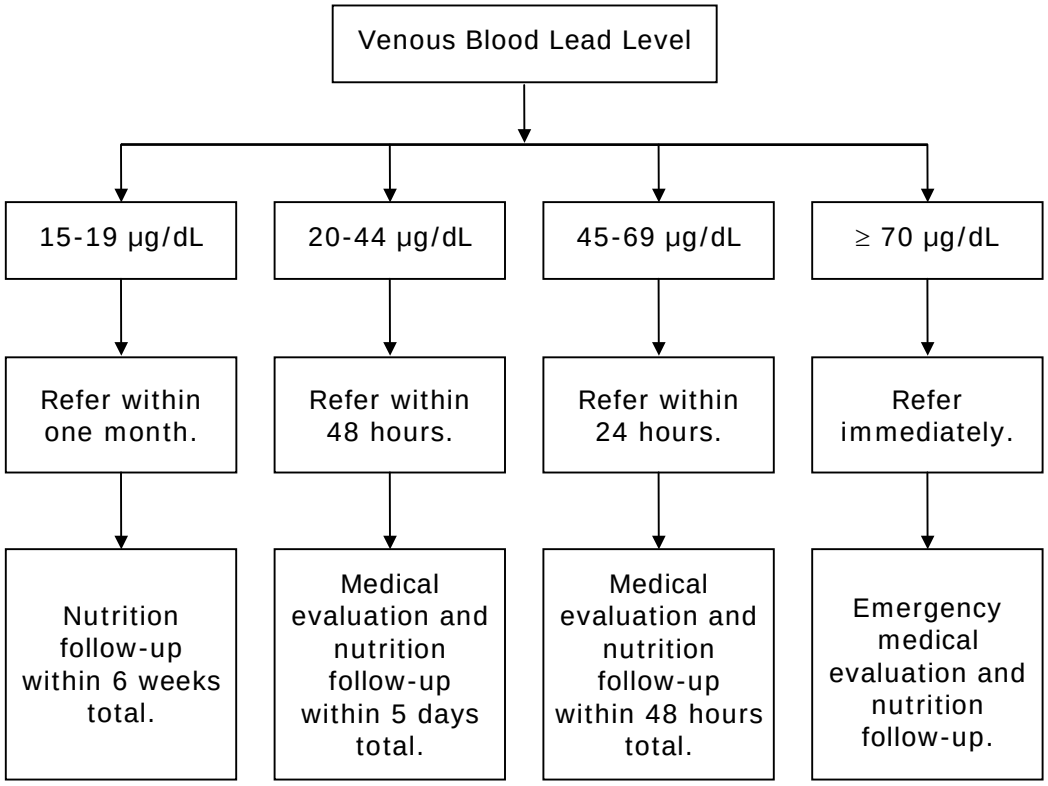
(6) Follow-up of Elevated Venous Levels (≥ 20 µg/dL)



See Timelines for Medical and Nutritional Follow-up and Timelines for Environmental Follow-up for time frames for referrals.

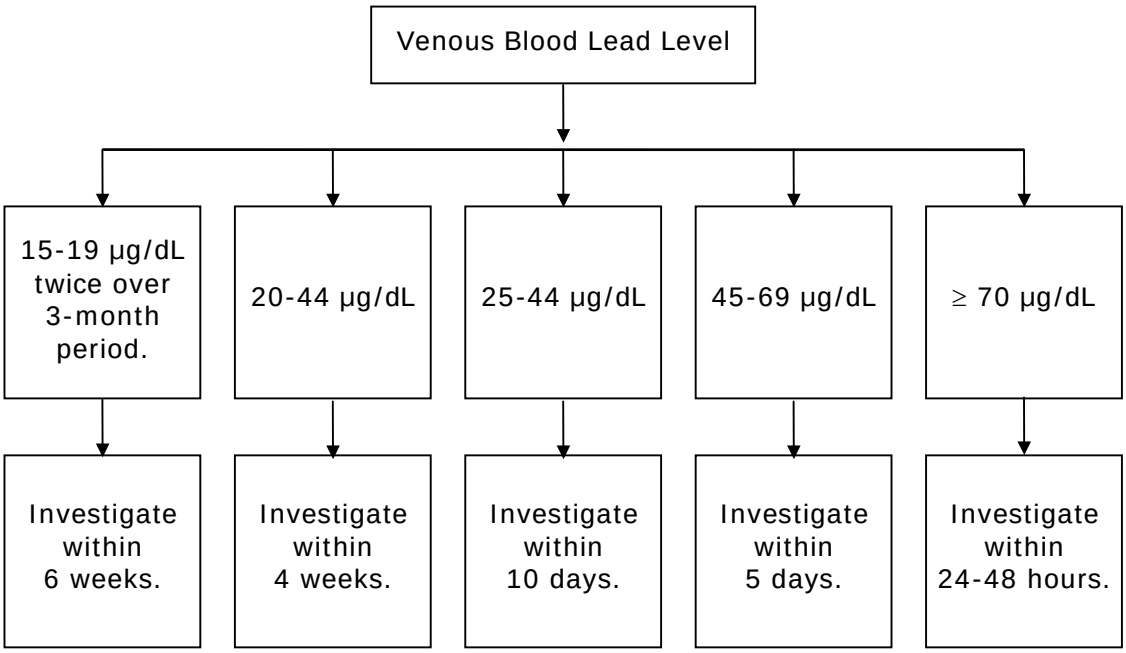
Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(7) Timelines for Medical and Nutritional Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(8) Timelines for Environmental Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(9) Resource Persons for Lead Testing, Screening, and Case Management

For more information or assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, 515-281-3479 or 1-800-972-2026.

g. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (PAP) smears are recommended at age 18 years for all females if sexually active or if the sexual history is thought to be unreliable. High-risk individuals for cancer in situ are those who:

- Begin sexual activity in early teen years, and
- Have multiple partners.

Sexually active females should receive family planning counseling, including pap smears, self breast exams, and education on prevention of sexually transmitted disease (STD).

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If first smear is unsatisfactory, repeat as soon as possible.

h. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

- Multiple sexual partners or a sexual partner with multiple contacts.
- Sexual contacts with a person with culture-proven gonorrhea.
- A history of repeated episodes of gonorrhea.
- Discuss how to use contraceptives and make them available.
- Education on the prevention of STDs.

i. Chlamydia Test

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., age less than 25, multiple sexual partners with multiple sexual contacts). Recent sexual partners of persons with positive tests for STD.

- Educate on the prevention of STD.
- Educate on the importance of contraception to prevent pregnancy.

4. Other Services

Other services that must be included in the screening examination are:

- Immunizations
- Assessment of nutritional status
- Vision screening
- Hearing screening

a. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90% of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in February 2002 reflect changes and challenges in vaccine delivery.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See ACIP Recommended Immunization Schedule.) You can obtain information about immunizations by contacting 1-800-232-4636 or 1-800-831-6293.

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See Contraindications and Precaution for Immunization for a guide to contraindications to immunization. http://www.cdc.gov/vaccines/pubs/ACIP-list.htm

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

Under the leadership of National Vaccine Advisory Committee (NVAC), standards were recently revised (http://www.cdc.gov/vaccines/recs/vac-admin/). The revised standards focus on:

- Making vaccines easily accessible
- Effectively communicating vaccination information
- Implementing strategies to improve vaccination rates
- Developing community partnerships to reach target patient populations.

Provide the recommended childhood immunization schedule for the United States for January-December of the current year. These recommendations are approved by:

- The Advisory Committee on Immunization Practices (ACIP).
- The American Academy of Pediatrics.
- The American Academy of Family Physicians.

The recommended childhood and adolescent immunization schedule can be accessed on the following web sites: http://www.cdc.gov/vaccines, www.aap.org, or www.aafp.org.

b. Nutritional Status

To assess nutritional status, include:

- Accurate measurements of height and weight.
- A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures on Hemoglobin and Hematocrit for suggested screening ages).
- Questions about dietary practices to identify:
  - Diets that are deficient or excessive in one or more nutrients.
  - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
  - Food allergy, intolerance, or aversion.
  - Inappropriate dietary alterations.
- Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.
- If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to the following criteria:
  - Parents or grandparent, at 55 years of age or less, underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
  - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

(1) Medical Evaluation Indicated (0-12 months)

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- Measurements
  - Weight/height < 5th percentile or > 95th percentile (NCHS charts).
  - Weight/age < 5th percentile.
  - Major change in weight/height percentile rank. (A 25 percentile or greater shift in ranking.)
  - Flat growth curve. (Two months without an increase in weight/age of an infant below the 90th percentile weight/age.)
- Laboratory tests
  - < Hct 32.9%
  - < Hgb 11 gm/dL (6-12 months)
  - ≥ 15 µg/dL blood lead level
- Health problems
  - Metabolic disorder.
  - Chronic disease requiring a special diet.
  - Physical handicap or developmental delay that may alter nutritional status.
- Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

(2) Medical Evaluation Indicated (1-10 years)

Use these criteria for referring a child for further medical evaluation of nutrition status:

- Measurements
  - Weight/length < 5th percentile or > 95th percentile for 12-23 months.
  - BMI for age < 5th percentile or > 95th percentile for 24 months and older.
  - Weight/Height < 5th percentile or > 95th percentile (NCHS charts).
  - Weight/Age < 5th percentile.
  - Major change in weight/height percentile rank. (A 25 percentile or greater shift in ranking.)
  - Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.

- Laboratory tests

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

- Health problems
  - Chronic disease requiring a special diet.
  - Metabolic disorder.
  - Family history of hyperlipidemias.
  - Physical handicap or developmental delay that may alter nutritional status.

- Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

(3) Medical Evaluation Indicated (11-21 years)

Use these criteria for referring adolescents for further medical evaluation of nutritional status:

- Laboratory tests

	FEMALE		MALE	
Age	HCT %	HGB gm/dL	HCT %	HGB gm/dL
11 up to 12	35.4	11.9	35.4	11.9
12 up to 15	35.7	11.8	37.3	12.5
15 up to 18	35.9	12.0	39.7	13.3
18 up to 21	35.7	12.0	39.9	13.6

- Health problems
  - Chronic disease requiring a special diet.
  - Physical handicap or developmental delay that may alter nutritional status.
  - Metabolic disorder.
  - Family history of hyperlipidemias.
  - Substance use or abuse.
  - Any behaviors intended to change body weight such as self induced vomiting, binging and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise.
  - Physical examination. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

Source: *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*. U.S. Department of Health and Human Services, September 1991.

c. Vision

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

(1) Birth Through Two Years of Age

Eye evaluations of infants and children birth through two years of age should include:

- Eyelids and orbits
- External examinations
- Eye muscle balance
- Pupils
- Red reflex
- Motility
- Monocular fixational ability assessment

(2) Two to Four Years of Age

In addition to all the eye evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ years, children should receive objective vision testing using picture cards. (See the following chart for suggested tests.)

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the child is untestable on the second attempt.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the ophthalmoscope is used to evaluate the optic nerve and posterior eye structures.

VISION SCREENING GUIDELINES

Function: Recommended Tests	Referral Criteria	Comments
Distance visual acuity: ♦ Snellen letters ♦ Snellen numbers ♦ Tumbling E ♦ HOTV ♦ Picture tests • Allen figures • LH test	**Ages 3-5 years:** 1. <4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., <10/20 or 20/40) or 2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40) **Ages 6 years and older:** 1. <4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., <10/15 or 20/30) 2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30)	1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older. 2. Testing distance of 10 ft is recommended for all visual acuity tests. 3. A line of figures is preferred over single figures. 4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.
Ocular alignment:		
♦ Unilateral cover test at 10 ft or 3 m or ♦ Random-dot-E stereo test at 40 cm (630 s of arc)	Any eye movement <4 of 6 correct	

Source: Vision screening guidelines developed by the AAP Section on Ophthalmology Executive Committee, 1991-1992. ***Pediatrics***, Vol. 98 No. 1, July 1996.

(3) At Five Years and Older

Children five years and older should receive all the previously described eye examinations and screening described for younger children.

During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception.

As the child reaches school age, refractive errors that may require eye glasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia, farsightedness, can cause problems in performing close work.

Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning related vision problems.

d. Hearing

Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. Each child up to age 3 should have an objective hearing screen or documented parent refusal. See http://www.jcih.org/posstatemts.htm.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.

Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before 3 months.

All infants with confirmed hearing loss should receive intervention services before 6 months of age.

For information on audiologists in your area, see the early hearing detection and intervention system (EDHI) web site, www.idph.state.ia.us/iaehdi/default.asp or call 1-800-779-2001.

Objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify children with late onset hearing loss.

Thus, objective hearing screening for all children should be conducted during well-child health screening appointments according to the periodicity schedule. This includes regular surveillance of developmental milestones, auditory skills, parental concerns, and middle ear status.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following are 11 risk indicators associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed-onset hearing loss.

1. Caregiver concern* regarding hearing, speech, language, or developmental delay (Roizen, 1999)

2. Family history* of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).

3. Neonatal intensive care of > 5 days, or any of the following regardless of length of stay: ECMO, *assisted ventilation, exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix), and hyperbilirubinemia requiring exchange transfusion (Fligor et al., 2005; Roizen, 2003).

4. In-utero infections, such as CMV, *herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et all., 2006; Rivera et al., 2002).

5. Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).

6. Physical finding, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).

7. Syndromes associated with hearing loss or progressive or late-onset hearing loss, *such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson (Nance, 2003).

8. Neurodegenerative disorders, *such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).

9. Culture-positive postnatal infections associated with sensorineural hearing loss, *including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).

10. Head trauma, especially basal skull/temporal bone fracture* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).

11. Chemotherapy* (Bertolini et al., 2004).

For additional information on hearing screening see *Selective Screening, Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. www.brightfutures.aap.org.

E. BASIS OF PAYMENT

Payment is made directly to enrolled advanced registered nurse-practitioners practicing in a recognized specialty area. The basis of payment is a fixed fee. The lower of the billed charges or the fixed fee is paid.

The basis of payment for CRNA services is a fee schedule based on the HCPCS codes, with base units as established by the Centers for Medicare and Medicaid Services for the Medicare program.

For CRNAs who do not receive medical direction from an anesthesiologist, the CRNA services are reimbursed on the basis of 80% of the amount that would be payable to an anesthesiologist for the same surgical procedure. Use the modifier of QZ along with the appropriate anesthesia CPT code.

When the CRNA receives medical direction from an anesthesiologist who is not the CRNA's employer, reimbursement is made on the basis of 60% of the amount that would be payable to an anesthesiologist for the same surgical procedure. Use the modifier of QX along with the appropriate anesthesia CPT code.

When the CRNA is employed by the anesthesiologist, the anesthesiologist shall submit the claim under the anesthesiologist's provider number. The entire payment will be made to the anesthesiologist.

For medical direction to be reimbursable to the anesthesiologist, the anesthesiologist must be physically present in the operating suite. (Note the use of "operating suite" and not "operating room.")

Time is billed by minute. Please note the total number of minutes in field 24G on the CMS 1500 claim form.

F. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes are divided into three levels.

- Level 1 is the current CPT-4 codes.
- Level 2 codes are specifically designed regional five-digit codes beginning with letters A through V, approved by the federal Centers for Medicare and Medicaid Services.
- Level 3 codes are specifically designed local codes beginning with letters W through Z.

Note that most Level 3 codes (i.e. "local" codes) have been cross-walked to either CPT or Level 2 codes, pursuant to requirements of the Health Insurance Premium and Portability Act (HIPAA) of 1996. The only Level 3 "local" codes that now remain are those that would be considered an "atypical" service by CMS, whose standard for such is:

- Not rendered by a traditional health care provider;
- Not a typical health care service; and
- Not a service normally payable by other health insurance plans or programs.

Claims submitted without a procedure code and appropriate ICD-9-CM diagnosis code will be denied.

After consultation with the Board of Nursing and the professional organizations associated with advanced registered nurse practitioners, the Department has established advanced registered nurse practitioner payment provisions as follows:

1. Procedure Codes

Advanced registered nurse practitioners are able to bill for services with the appropriate procedure and diagnosis codes described above, consistent with their licensure, scope of practice, specialty area, and the service being rendered. CRNAs should use standard applicable CPT procedure codes for anesthesia procedures they perform.

2. Modifiers

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Modifiers are found in CPT-4. Additional modifiers are shown below.

Modifiers	Description
EP	Service provided as a result of the findings from a Care for Kids (EPSDT) screening exam.
FP	Services related to family planning.
LT	Left side (used to identify procedures performed on the left side of the body).
RT	Right side (used to identify procedures performed on the right side of the body).
U1	Care for Kids (EPSDT) screen with referral for treatment.
32	Annual routine physical required for RCF resident.

Bill screening examinations with the preventive office visit code for the examination.

Iowa Department of Human Services
Iowa Medicaid Enterprise

REQUEST FOR PRIOR AUTHORIZATION

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last) (First) (Initial)			2. Patient Medicaid Identification No.	3. Date of Birth Month Day Year	4. Provider Taxonomy No.
5. Provider Phone No	6. Provider Fax	7. Provider NPI	8. Dates Covered by Request		
			From		To
9. Dispensing Provider Name			Mo. Day Year		Mo. Day Year
10. Service Location Street Address			12. PRIOR AUTHORIZATION NO. (To be assigned by IME) Enter this number in the appropriate box when submitting the claim form for the services authorized.		
11. Service Location City, State, Zip					

13. Reasons For Request (Provide specific information and use additional sheet if necessary)

SERVICES TO BE AUTHORIZED

14. Line No.	15. Procedure, Supply, Drug To Be Provided or NDC if applicable	16. Code, HCPCS, CPT or CDT	17. Units of Service	18. Authorized Units (leave blank)	19. Amount Requested	20. Authorized Amount (leave blank)	21.Status (leave blank)
01							
02							
03							
04							
05							
06							
07							
08							
09							

22. IMPORTANT NOTE: In evaluating requests for prior authorization the need for treatment will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service by calling the ELVS line at 1-800-338-7752 (locally at 515-323-9639) or by accessing the Web Portal. Contact Provider Services at 800-338-7909 or (locally) 725-1004 for assistance in accessing the Web Portal.

23. Requesting provider

Signature of Authorized Representative Date

PRIOR AUTHORIZATION REVIEWER USE ONLY

24. MEDICAID SERVICES ARE HEREBY ❑ APPROVED ❑ DENIED FOR THE MEMBER UNDER TITLE XIX. THIS AUTHORIZATION APPLIES ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.

25. Comments or Reasons for Denial of Services

*PROVIDER INFORMATION, PROCEDURE, SUPPLY, OR DRUG CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM.

470-0829 (Rev. 8/08)

26. Signature

Iowa Medicaid Enterprise Date

G. REQUEST FOR PRIOR AUTHORIZATION

Since there are different requirements for requesting prior authorization for services than for drugs, sections 1, 2, and 3 relate to requests for services; section 4 deals with requests for drugs.

1. How to Use

For those services requiring prior approval, form 470-0829, *Request for Prior Authorization*, must be completed and submitted to The IME Medical Services Unit. To view a sample of this form on line, click here. Do not use this form unless Medicaid requires prior approval for the service being provided.

The IME Medical Services Unit will review the request and make a determination of coverage. When a determination has been made, the form will be returned to you. If the service is approved for coverage, you may then submit your claim for reimbursement.

IMPORTANT: Do not return the prior authorization form with the claim. You need to place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the billing system will then verify that the service has been approved for payment.

2. Instructions for Completing Request for Prior Authorization

Patient Name: Complete the last name, first name, and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.

Patient Identification Number: Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).

County No.: This is the number of the county where the member resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.

Date of Birth: Copy the patient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).

Provider Phone No.: Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

Provider No.: Leave blank.

Pay to Provider No.: Enter the seven-digit provider number assigned to you by the Iowa Medicaid program.

Dates Covered by This Request: Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period.

Provider Name: Enter the name of the provider requesting prior authorization.

Street Address: Enter the street address of the provider requesting prior authorization.

City, State, Zip: Enter the city, state, and zip of the provider requesting prior authorization.

Prior Authorization No.: Leave blank. The IME Medical Services Unit will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

Reason for Request: Provide the required information in this area for the type of approval being requested. (For enteral products, enter the number of cans or packets administered per day.)

SERVICES TO BE AUTHORIZED

Line No.: No entry is required.

Describe Procedure, Supply, Drug to be Provided or Diagnosis Description: Enter the description of the service or services to be authorized. (For enteral products, enter the product name and NDC number.)

Procedure, Supply, Drug or Diagnosis Code: Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

Units of Service: Complete with the amount or number of times the service is to be performed. (For enteral products, enter the number of cans or packets dispensed for the time span requested.)

Authorized Units: Leave blank. The IME Medical Services Unit will indicate the number of authorized units.

Amount: Enter the amount that will be charged for this line item.

Authorized Amount: Leave blank. The IME Medical Services Unit will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

Status: Leave blank. The IME Medical Services Unit will indicate "A" for approved or "D" for denied.

Provider Name: Complete the name of the provider who will provide services, if other than the requester of prior authorization.

Telephone No.: Enter the telephone number of the provider who will provide services, if other than the requester of prior authorization. This area is optional.

Provider No.: Enter the seven-digit Medicaid provider number of the treating provider, if other than the requester of prior authorization.

Pay to Provider No.: Enter the seven-digit group provider number for the treating provider, if other than the requester of prior authorization.

Street Address, City, State, Zip: Complete the street address, city, state and zip of the provider who will provide services, if other than the requester of prior authorization.

Requesting Provider: Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.

IME USE ONLY

Medicaid Benefits Requested are Hereby: Do not complete. The IME Medical Services Unit will complete this item after evaluating the request.

Comments or Reason for Denial of Benefits: Do not complete. The IME Medical Services Unit will complete this section should this request be denied.

Signature: Do not complete. The person making the final decision on this request will sign and date.

3. Electronic Prior Authorization Requests

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for Prior Authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- **Staple** the additional information to form 470-3970, *Prior Authorization Attachment Control*. (To view a sample of this form on line, click here.)
- Complete the "attachment control number" with the same number submitted on the electronic prior authorization request. The IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.
- Mail the *Prior Authorization Attachment Control* with attachments to:

  IME Medical Services Unit
  P.O. Box 36478
  Des Moines, Iowa 50319

  Or FAX the information to the Prior Authorization Unit at: 515-725-1356.

Once the IME receives the paper attachment, it will manually be matched up to the electronic prior authorization using the attachment control number and then processed.

Note: This procedure does not apply to drug prior authorizations. See How to Request Authorization for Drugs, below.

4. How to Request Authorization for Drugs

Completed drug prior authorization requests must be submitted **via FAX** to the IME Drug Prior Authorization Unit at 800-574-2515. The practitioner must submit DRUG prior authorization requests.

Iowa Department of Human Services

Iowa Medicaid Program

Prior Authorization Attachment Control

Please use this form when submitting a prior authorization electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic prior authorization. Otherwise the electronic prior authorization and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

Pay-to-Provider Number

Member Name _____

Member State ID Number

Date of Service _____/_____/_____

Type of Document

_____

_____

_____

Return this document with attachments to:

IME Prior Authorization
P.O. Box 36478
Des Moines, IA 50315
PA Fax: 515-725-1356

The instructions for completing drug prior authorization forms are in the *Prescribed Drugs Manual,* section III. C. REQUEST FOR PRIOR AUTHORIZATION. You can obtain a drug prior authorization form:

- From the web site www.iowamedicaidpdl.com/index.pl/pa_forms or
- By calling the drug prior authorization help desk at (515) 725-1106 (local calls) or 877-776-1567.

Regular working hours for the provider help desk are Monday through Friday, 8:00 a.m. to 5:00 p.m. After-hours calls for emergency requests will be routed to the pharmacy pager voicemail system where an on-call pharmacist will be available for assistance.

The pharmacist reviewer will make a decision and respond within 24 hours of the request. In evaluating requests for prior authorization, the reviewer will consider the drug from the standpoint of published criteria only.

If a prior authorization request is denied, a letter of denial will be faxed to both the prescriber and the pharmacist. A letter of denial will be mailed to the member.

Upon approval of a prior authorization request, a letter of approval will be faxed to the prescriber and the pharmacy indicating the prior authorization number and dates of authorization.

NOTE: When approval of a request is granted, this does not indicate validity of the prescription, nor does it indicate that the member continues to be eligible for Medicaid. If you are not billing on the point-of-sale system, it is your responsibility to establish that the member continues to be eligible for Medicaid, either by:

- Calling the eligible verification system (ELVS) at (515) 323-9639 (local calls) or 800-338-7752; or
- Checking the IME web portal: http://ime-ediss.noridian.com/iowaxchange/

H. CMS 1500 CLAIM FORM

Bill for ARNP services using form CMS-1500, *Health Insurance Claim*. To view a sample of the claim form on line, click here.

1. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the CMS-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED**. Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED**. Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid member is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED**. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL**. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL**. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN**. Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**SITUATIONAL**. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN**. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL**. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED**. If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL**. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL**. No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	**SITUATIONAL**. Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL**. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL**. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		**OPTIONAL**. No entry required.
17b.	NPI	**SITUATIONAL**. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL**. No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL**. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL**. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED**. Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL**. If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE	**REQUIRED**. Enter month, day, and year under both the "From" and "To" columns for each procedure, service, or supply. If the "From-To" dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a monthly basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED**. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL**. No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED**. Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED**. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED**. Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED**. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL**. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK**. The claim will be returned if any information is entered in this field.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	**LEAVE BLANK** **REQUIRED** Enter the NPI of the provider rendering the service.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL**. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE**. Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	**OPTIONAL**. No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED**. Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL**. Required if the member has other insurance **and** the insurance has made a payment on the claim. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED**. Enter the amount of total charges less the amount entered in field 29.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED**. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED**. Enter the name and address associated with the rendering provider.
32a.	NPI	**OPTIONAL**. Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED**. Enter the name and complete address of the billing provider. The address must contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org.
33a.	NPI	**REQUIRED**. Enter the ten-digit NPI of the billing provider.
33b.		**REQUIRED**. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the confirmed taxonomy code, access imeservices.org.

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click here.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. The IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- Do **not** attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:
  Medicaid Claims
  P.O. Box 150001
  Des Moines, Iowa 50315

Once the IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

I. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

TO: (1) R.A. NO.: 3(2)6 WARR NO.: 9(3)9 DATE PAID: 10/22/07 (4) PROV. NUMBER: (5) PAGE: (6) 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500 (7)								* * * CLAIM STATUS: PAID (8)					
ORIGINAL CLAIMS: (9)			(11)			(12)	(13)	(14)	(15)	(16)			(17)
		(10)	3-07290-00-015-0941-00		(21)	172.00	0.00	85.07	1.00				000 000
		(18) 01	(19) 10/04/07	99242 (20)	1	172.00	(22)	85.07 (24)	1.00 (25)	(26)		F	000 000
							(23)						
			3-07292-00-009-0053-00			69.00	0.00	32.36	0.00	(27)			000 000
		01	07/06/07	99212	1	69.00		32.36	0.00			F	000 000
			3-07288-00-010-0484-00			298.00	0.00	145.03	0.00				000 000
		01	07/11/07	99212 25	1	69.00		32.36	0.00			F	000 000
		02	07/11/07	29405	1	197.00		112.67	0.00			F	000 000
		03	07/11/07	A4590	1	32.00		0.00	0.00			K	177 000
			0-07281-22-009-0270-00			128.00	0.00	71.46	0.00				000 000
		01	06/14/07	20550	1	122.00		68.06	0.00			F	000 000
		02	06/14/07	J3301	2	6.00		3.40	0.00			F	000 000
4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..						667.00	0.00	333.92	1.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 2

**** PATIENT NAME **** LAST	FIRST	MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500									* * * CLAIM STATUS: DENIED					
ORIGINAL CLAIMS:														
				3-07289-00-011-0880-00			69.00	0.00	0.00	0.00			499	000
			01	07/12/07	99212	1	69.00		0.00	0.00			K 000	000
1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..							69.00	0.00	0.00	0.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 3

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REMITTANCE T O T A L S					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	4	---------	667.00	333.92
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	1	---------	69.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					333.92

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

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177 THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. 1

499 INVALID OR MISSING MEDIPASS REFERRAL FOR RECIPIENT. 1

Iowa Department of Human Services

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

NPI Billing Provider Number

Member Name _____

Member State ID Number

Date of Service _____/_____/_____

Type of Document

_____

_____

_____

Return this document with attachments to:

IME Claims
P.O. Box 150001
Des Moines, IA 50315

470-3969 (Rev. 7/07)

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	*Remittance Advice* page number.
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

NO.	FIELD NAME	DESCRIPTION
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.

NO.	FIELD NAME	DESCRIPTION
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.